JULY 1, 1949

MODERN MEDICINE

The Journal of Diagnosis and Treatment

Firsthand Account
(see page 43)

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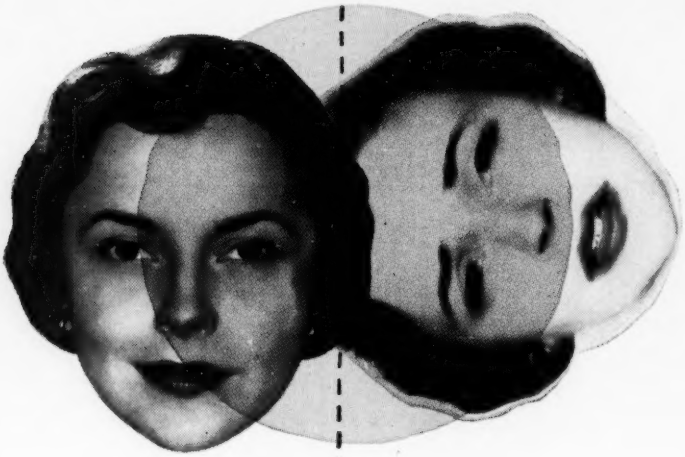

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—"*inconspicuous side effects*"[1]

Prompt, complete relief in bronchial asthma and associated conditions . . . yet "causes very little central nervous stimulation and produces little or no pressor action."[1]

85% – 90% effective relief in over 1400 patients during an exacting 8-year clinical study.

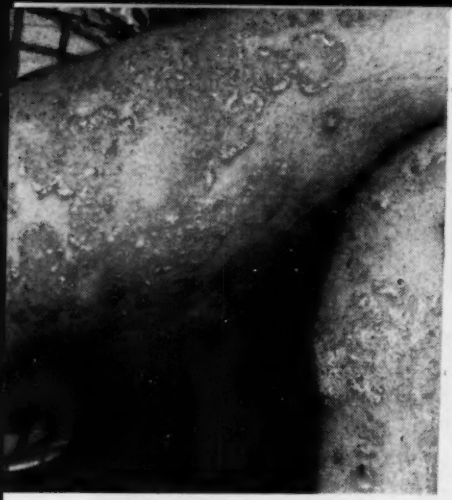
Increased vital capacity . . . better feeling of well-being . . . essentially free from undesirable side actions.

Its name is **NETHAPHYL®**

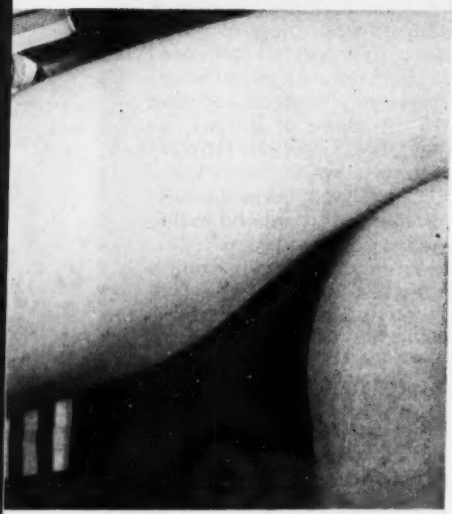
Each capsule contains: Nethamine® Hydrochloride 50 mg., Butaphyllamine® 0.12 Gm., and phenobarbital 15 mg.
Also available in half-strength.

CINCINNATI MERRELL 1828 U. S. A.

1—*Hansel, F. K.: Ann. Allergy, 5:397, 1947.*



Before Use of Riasol



After Use of Riasol

RIASOL in the spotlight in PSORIASIS

Each passing week brings **RIASOL** into clearer view as an effective means for dealing with psoriasis. Physicians are focusing much attention on this outstanding prescription because they know from experience that it really works.

Clinical tests show that **RIASOL** is unusually efficacious in clearing up scaly, psoriatic lesions in most cases. Recurrences are generally minimized. Patients are so grateful for the prompter cosmetic relief usually afforded by **RIASOL** that they cooperate 100% in following instructions.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

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RIASOL FOR PSORIASIS

Doctor, here's a time-saving aid for you . . .

. . . a helpful guide for the EXPECTANT MOTHER

When you are called upon to advise the mother-to-be on routine hygienic procedures, you can save valuable time by using the free Ivory Handy Pad on "The Hygiene of Pregnancy."

Each of the 50 leaflets in this Handy Pad contains printed instructions covering approved hygienic rules on exercise, rest, diet and allied subjects as they relate to the parturient patient. Ample space is provided for your own additional written instructions. Thus, simply by handing a leaflet to your patient you can furnish the required information—in permanent form, easy to consult.

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"The Hygiene of Pregnancy" is one of four different Handy Pads, developed for you by Ivory Soap. Each Handy Pad is designed to meet a definite need in practice. It contains no controversial matter and includes only professionally accepted data.

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Please send, at no cost, one of each Ivory Handy Pad checked:

_____No. 1: "Instructions for Routine Care of Acne."
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MODERN MEDICINE

THE JOURNAL OF DIAGNOSIS AND TREATMENT

Schering

is pleased to announce that it has made available for use in the treatment of

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specially purified undecylenic acid for oral administration

Attention has recently been drawn to "an interesting approach"[1] to the control of psoriasis and neurodermatitis. Perlman[2] has reported that following the oral use of undecylenic acid, psoriasis was relieved completely in 3 out of 17 patients, and was partially relieved in the remainder. "Relief of itching is sometimes noticed as early as two days after institution of treatment . . . undecylenic acid seems to hold a great deal of promise in the improvement and possible prevention of recurrences of psoriasis and neurodermatitis."[2]

SEVINON* is available in gelatin capsules containing 0.44 Gm. undecylenic acid, highly purified for oral use. The dosage employed by Perlman[2] corresponds to 5 to 6 capsules three times daily by mouth, continued in some cases for as long as six months.

1. Undecylenic Acid and Psoriasis, editorial, J.A.M.A. 139:460, 1949.
2. Perlman, H. H.: J.A.M.A. 139:344, 1949.

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SEVINON

SCHERING INC

Contents for July 1 1949

VOL. 17, NO. 13

THE MAN ON THE COVER, like Frank Fay's Harvey, is invisible but none the less real. He is symbolic of the British doctor who is now completing his first year's practice under the British National Health Service program. How is he getting along? What does he think of the system? Of the remuneration? What are his fears of regimentation and bureaucracy? What is his prognosis for medical practice on the British Isles? MODERN MEDICINE commissioned a trained reporter on science and medicine to get the answers for you firsthand. The first of his two articles begins on page 43.

a new antihistamine

ointment *for*

relief of pruritus

Thephorin, the new antihistamine with minimal side reactions, is now available in 5 percent ointment for effective relief of distressing allergic skin manifestations. In most cases Thephorin Ointment quickly relieves the discomfort of atopic dermatitis, chronic contact dermatitis, lichenified eczema, pruritus ani, pruritus vulvae, urticaria and drug dermatitis. 1½ oz. tubes and 1 lb. jars.

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Thephorin ®

Ointment

'Roche'

brand of phenindamine

Contents for July 1 1949

CONTINUED

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ARGYROL not only has proven effectiveness in restoring normal function, but its use wholly avoids such undesirable side reactions.

The ARGYROL Technique

1. The nasal meatus...by 20 per cent ARGYROL instillations through the nasolacrimal duct.
2. The nasal passages...with 10 per cent ARGYROL solution in drops.
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Its Three-Fold Effect

1. Decongests without irritation to the membrane and without ciliary injury.
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ARGYROL — *the medication of choice in treating para-nasal infection.*

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Practical, Effective Blood Test Announced Fo

CANCER DIAGNOS

Paper Presented Before
American Association for
Cancer Research

SIMPLIFIED REAGENTS NOW AVAILABLE FOR TESTING IN YO

AMERICAN REAGENTS C

For Early

SIS

Charles Huggins, M.D., President of the American Association for Cancer Research, stated* that comparative studies of the blood serum of cancer patients and normal and other noncancerous individuals have revealed significant differences that constitute "what is for all practical purposes a simple, cheap, and reasonably sure blood test for cancer."

Tests on almost 300 individuals were performed under the direction of Huggins and his associates and reported in Cancer Research, March, 1949. These cases were equally divided into cancer patients, apparently healthy persons and patients with noncancerous diseases. Results proved positive for all cancer cases, negative for all normal persons, and negative for all other patients except those with lung tuberculosis and acute massive infections. Since these latter conditions are readily diagnosed, the test will not confuse cancer with other conditions.

If the test proves positive, it does not locate the cancer or determine the type. A positive reaction indicates cancer; further study is then required.

One of the abnormalities noted in all cancerous bloods is defective coagulation. Iodoacetates have been found to be one of the most effective inhibitors of thermal coagulation.† In this test a titration is made to determine the least amount of inhibitor necessary to prevent coagulation. Thus a smaller quantity indicates the greater abnormality.

As a result of our simplification of the reagents, as outlined by Huggins, it is now practical for any physician to perform this test for cancer in his own office.

The simplified iodoacetate reagent is supplied in packages of 5 ampules. Each ampule, when diluted to 10 c.c. with distilled water gives sufficient material for performing three tests. The two other necessary reagents are included in the set which provides enough material for 15 tests.

Complete instructions are included.

* Paper presented before annual meeting of American Association for Cancer Research, April, 1949.

† Huggins, C., and Jensen, E. V., Thermal Coagulation of Serum Proteins. I. The Effects of Sulfhyryl Groups and of Iodoacetate and Iodoacetamide on Coagulation. In press.

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COMPANY

COMPLETE SET $7.50

Sufficient for 15 tests

AMERICAN REAGENTS COMPANY
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Please send _____ sets of reagents (each set sufficient to perform 15 tests) for the iodoacetate cancer detection test at $7.50 per set.

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City..... Zone..... State.....

LETTER FROM THE EDITOR

Dear Reader:

When Dr. Bernard A. Sachs' provocative article on the possible role of dietary cholesterol in the development of atherosclerosis was selected by our Board of Editors to head the Medicine section of the April 15 issue of MODERN MEDICINE we knew that it was controversial. But we did not suspect that our Medical Forum would have to be expanded to nearly twice its usual size, 6 pages in all, to take care of the debate called forth.

Letters received were not routine expressions of approval or disagreement, but detailed accounts of experiments and observations, as well as notes suggesting that we invite other authorities to participate.

Pathologists, cardiologists, internists, specialists in diabetes, and laboratory researchers contributed their experiences to make the forum a cross section of contemporary professional opinion.

We believe that this symposium again proves MODERN MEDICINE *the* journal of medical progress.

Heart disease is a major concern of most clinicians. Its treatment is a large part of most practices. Cardiac conditions are a leading cause of death among physicians. Thus the Medical Forum on the use of quinidine for auricular fibrillation, pages 71 to 73 in this issue, also is of personal as well as professional interest.

But every Medical Forum is rewarding reading. Each is a series of special articles on topics of current medical concern. Since the first of the year 72 discussions have been published, representing the most alert and informed medical thinking of our time.

PAZILLIN is a uniform suspension of crystalline procaine penicillin G, 300,000 units/cc., in sesame oil and aluminum monostearate, and is stable for 1 year without refrigeration.

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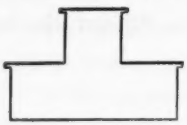
Correspondence

Communications from the readers of MODERN MEDICINE *are always welcome. Address communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Two-Step Test Explained

TO THE EDITORS: I noticed a query on the Master's "two-step" test in the Apr. 1 issue of *Modern Medicine* (p. 28). The reply was not entirely clear.



Bringing in question of foot pounds of work per minute and percentage of efficiency was more apropos when blood pressure and pulse responses were utilized. The test, as performed in the last ten years, uses the electrocardiogram only. Tables give the number of trips the patient should walk for his age, sex, and weight. Electrocardiograms are taken before, immediately following, and two and six minutes after the minute and a half walk.

A positive test is present if an RS-T depression of more than ½ mm. below the isoelectric (P-R) level occurs or if the upright T wave becomes isoelectric or inverted. When a single "two-step" test is negative, a double is essayed. The latter consists of walking twice the number of trips in three minutes instead of a minute and a half.

When the single "two-step" and double "two-step" are negative, coronary insufficiency is practically excluded. When they are positive, coronary insufficiency is present although it may be either organic or functional.

ARTHUR M. MASTER, M.D.
New York City

Therapy for Flat Angiomas

TO THE EDITORS: I would like to bring to the attention of your readers an interesting problem which I am working on. In the clinic for sclerotherapy at the Stuyvesant Polyclinic, New York City, I am doing a series of cases on a new injection treatment for flat angiomas. This type of nevus has never been handled satisfactorily before, and preliminary cases have turned out very successfully.

I know the profession in general will be glad to learn that there is a clinic for the treatment of this difficult disorder and that they can send their worthy patients there. This will help to build up a series for future publication, which is what the clinic is interested in.

H. I. BIEGELEISEN, M.D.
New York City

Helpful and Interesting

TO THE EDITORS: I am a young G.P. in a rather remote area in Idaho. I find your magazine very helpful and interesting.

STANLEY G. SEDLAR, M.D.
Carey, Idaho

for emotional equilibrium in the menopause

BENZEBAR* not only frequently alleviates the depression you see in menopausal patients, but also the nervousness.

'BENZEBAR' is a logical combination of Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.) and phenobarbital. Thus, it provides the unique improvement of mood characteristic of 'Benzedrine' Sulfate and the mild sedation of phenobarbital. These two established agents work together to stabilize the patient's emotions and to restore her zest for life and living. ***Smith, Kline & French Laboratories, Philadelphia***

Benzebar

for the depressed and nervous patient

*'Benzedrine' and 'Benzebar' T.M. Reg. U.S. Pat. Off.

Pinworm Therapy

TO THE EDITORS: Your Consultant's answer to the question on pinworm eradication (Apr. 1, 1949, p. 28) is characteristic of many incomplete treatments for such chronic conditions and would never succeed.

Success depends entirely on the following procedure:

1] Gentian violet, 1 tablet, three times daily in three courses of eight days each with eight days' rest (a total of 72 tablets).

2] Strong soapsuds enema at bedtime. Then bathe all parts, anus to hips and perineum, with Lysol solution (1 tsp. to 4 qt. of water), dry with rough towel, and apply quinine sulfate ointment in carbolized petroleum jelly (1 dram to 2 oz.).

3] Then wash hands (nurse and patient) in the Lysol solution. Paint ends of fingers with 2% tincture of iodine. This removes pinworms and ova from under nails, the cause of reinfection.

This is a forty-eight-day treatment and, like all successful treatments, is a little trouble—but so are pinworms.

F. A. ALLIN, M.D.

San Antonio, Tex.

► TO THE EDITORS: In reply to the question by M.D., New York, on eradicating severe pinworm infestation of the rectum, your Consultant in Proctology places all his confidence in the use of gentian violet orally *(Modern Medicine,* Apr. 1, 1949, p. 28).

My results with gentian violet in severe cases have been poor, even when a dozen courses of intensive treatment have been given. I recommend the following method as being the most successful in the truly severe and chronic case:

The patient is first given a cathartic. He then chews diphenan (½ tablet for child, 1 tablet for adult) three times daily on an empty stomach until all the 20 tablets in the bottle are used up. During this time, ammoniated mercury ointment is applied liberally to the anus every night (2% for child, 5% for adult).

It is rare indeed that a second course of treatment is necessary to effect a cure.

MAURICE L. STERN, M.D.

New York City

It Can Be Done

TO THE EDITORS: The following article is quoted word for word as it appeared in a local newspaper, *The Watertown Times,* on May 4, 1949.

NEW DOCTOR

A new doctor is coming in July and a new dentist about the same time; we got a barber in Sandy Creek as well as one in Lacona, so our hair doesn't grow down our necks, and it goes to show you what can be done if a bunch of fellows really get busy and try to put something over.

I reproduce the above in the hope that it may be copied by newspapers all over the country, because in its few short lines there is a world of implication. The small village of Sandy Creek in Oswego Co., N.Y., had one physician but wanted another one—its own decision, made as such and fulfilled.

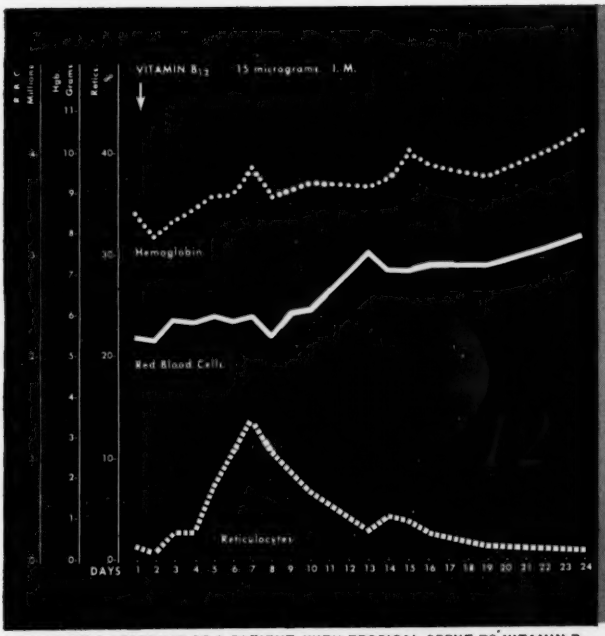
In a very unassuming and straightforward manner it proclaims that the U.S. citizen when he becomes a community force, on even the smallest village level, can think for himself, act and take care of his needs in a very efficient manner. As shown in the above article he not only will farm, work in a factory, and buy consumer goods, but also get his hair cut, his teeth fixed, and be provided with even more medical care.

And miracle of all miracles, he sees

(Continued on page 23)

Rubramin

SQUIBB VITAMIN B_{12} CONCENTRATE



HEMAPOIETIC RESPONSE OF A PATIENT WITH TROPICAL SPRUE TO VITAMIN B_{12}

"Vitamin B_{12}, per unit of weight, is the most effective antianemic substance known".

(Spies et al.: J.A.M.A. 139:521, 1949)

see next page . . .

Vitamin

Pernicious anemia in relapse

WHAT IS IT?

HOW DOES IT ACT?

WHAT IS THE DOSE?

Sq

. . *action and uses of* Rubramin

RUBRAMIN (Squibb Vitamin B_{12} Concentrate) contains the most active of the vitamins. Vitamin B_{12} is also the most potent hematogenic substance known. Rubramin is an aqueous solution, essentially protein-free, and therefore practically painless on injection.

". . . B_{12} appears to be the long-awaited liver extract factor. In minute amounts it appears to possess all of the effects of liver extract, both hematologically and neurologically." Dameshek, W.: Blood 4:75, 1949.

In patients with pernicious anemia and certain other macrocytic anemias, Rubramin produces a hematologic and neurologic response similar to that seen following injections of liver extract. Circulating erythrocytes promptly increase; red blood cell and hemoglobin response is quantitatively equal to that produced by liver extract. Rubramin relieves combined system disease in patients with pernicious anemia. As is true with liver extract therapy, the degree of improvement depends upon the degree of involvement before treatment is started.

"Five of 6 patients with peripheral neuritis and combined degeneration of the cord also showed improvement; in 3 the rate of improvement was unusually rapid." Hall & Campbell: Proc. Staff Meet. Mayo Clin. 23:591, 1948.

The suggested average dose for patients with pernicious anemia in relapse is 15 micrograms of vitamin B_{12} once or twice weekly until remission occurs. Larger doses, 30 micrograms once or twice weekly, may be given in severe cases, especially when neurologic manifestations are present.

Fifteen micrograms of vitamin B_{12} is approximately equivalent to 15 units of Liver Extract hematologically and neurologically. This dose may be given by injecting the contents of a 1 cc. Rubramin ampul, or 0.5 cc. of Rubramin in 5 cc. vials.

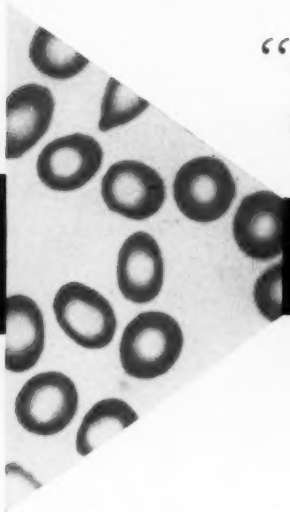
". . . approximately 1 microgram of Vitamin B_{12} appears to be the equivalent of 1 U.S.P. unit of liver or stomach mucosa." Hall, Morgan & Campbell; Proc. Staff Meet. Mayo Clin. 24:99, 1949.

Squibb Vitamin B_{12} Concentrate **Rubramin**

(See next page for indications and supply)

"large doses...
in concentrated form"

VITAMIN B_{12}



Rubramin

SQUIBB VITAMIN B_{12} CONCENTRATE

WHEN IS IT INDICATED?

Pernicious anemia with or without neurologic involvement, tropical and non-tropical sprue, nutritional macrocytic anemia and certain other macrocytic anemias all respond to Rubramin. In macrocytic anemias of pregnancy, some patients seem to do better when both Rubramin and folic acid are given. Patients unable to tolerate liver extracts may receive Rubramin without untoward effects.

"This new substance makes possible the administration of large doses of the specific factors in concentrated form which may prove to be a distinct advantage in the treatment of patients who are resistant to treatment with liver extract or in patients with severe neurologic involvement where early intensive therapy is desirable." Erf, L. A., and Wilmer, B. M.: Blood (to be published).

HOW IS IT SUPPLIED?

RUBRAMIN (Squibb Vitamin B_{12} Concentrate)

- 1 cc. ampuls, each ampul containing 15 micrograms of vitamin B_{12}. Boxes of 5.
- 5 cc. multiple-dose vials, 30 micrograms of vitamin B_{12} per cc.

Solution RUBRAMIN Crystalline (Squibb Crystalline Vitamin B_{12} Solution), 1 cc. ampuls, each ampul containing 15 micrograms of crystalline vitamin B_{12}.

SQUIBB

to it that he has these benefits without the benighted help of the Washington bureaucrat. We should be very much buoyed up in spirit as a result of these facts and feel that perhaps the American public individually and as a group will continue to care for themselves—unless, of course, a Federal Law is passed to the effect that we must give up our liberties entirely and be taken care of.

MARK L. HERMAN, M.D.
Adams, N. Y.

European Therapy for Sycosis Barbae

TO THE EDITORS: My answer to the question about treatment of "severe cases of sycosis barbae" *(Modern Medicine,* Apr. 15, 1949, p. 42) is as follows:

In Europe we used the following treatment in desperate cases with excellent results:

1] Epilation.

2] Removal of the crusts with 5% salicyl petroleum jelly.

3] Cleansing of the affected places with equal parts of alcohol and ether.

4] Every two days dabbing of the spots with 1% solution of brilliant green (a dye produced by I. S. Farben) dissolved in 70% alcohol.

CAESAR SCHOENLANK, M.D.
New York City

Chance to Remove Handicap

TO THE EDITORS: You are, undoubtedly, aware of the fact that the antivivisection societies have become a serious menace to the progress of medicine, dentistry, and pharmacy in this country.

In Illinois, the activities of these societies have resulted in a shortage of animals which has seriously handicapped both research and teaching.

(Continued on page 26)

This Man...

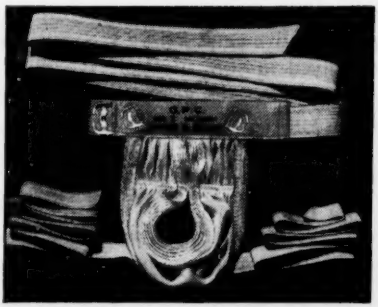
may need an

O.P.C.* No. 3 SUSPENSORY

Many men who must be on their feet all day report they find real relief from fatigue wearing a suspensory. In addition, many physicians prescribe a suspensory for the patient presenting tension of psychosomatic origin.

The O.P.C. No. 3 Suspensory is the most popular in the Bauer & Black line of famous suspensories because of its greater patient comfort and convenience, greater therapeutic value.

Ask your surgical supply dealer or drug store to show you O.P.C. No. 3. See for yourself what it can do for *your* patients.



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KOAGAMIN assures rapid, systemic control of venous or capillary bleeding, whether of external or internal origin.

KOAGAMIN reduces or makes unnecessary the need for cauterization or topical hemostatics, without danger of infection.

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Experiments are often postponed for several months, and classes have to be dismissed for lack of dogs.

To remedy this situation, a bill has been introduced in the State Legislature. It is called House Bill 650, and it is modeled after the Chicago Arvey Ordinance and a similar law passed last March by the State of Minnesota. This bill would permit all qualified institutions to receive the unclaimed stray dogs from the city pounds after the legal number of days for their redemption by the owner has elapsed. Thousands of stray dogs are put to death uselessly every year by the pounds and by the "humane" societies themselves; a fraction of these dogs would be sufficient to cover the needs of our medical schools.

Bill 650 is being fought strenuously by the antivivisectionists of Illinois and will be defeated unless the majority of the American people let the legislators know that they are in favor of its passage.

I would greatly appreciate your asking the Illinois readers of *Modern Medicine* to write and have their families, friends, and associates write immediately to their state representatives in Springfield urging these legislators to vote in favor of House Bill 650.

PIERO P. FOA, M.D.

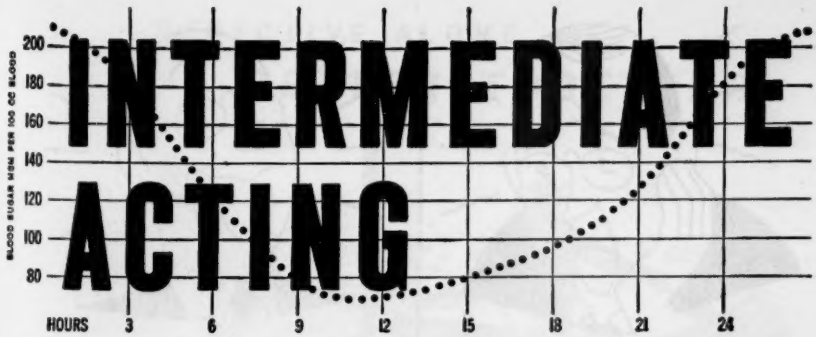
Chicago

Khellinin Instead of Khellin

TO THE EDITORS: An article in *Modern Medicine,* May 15, 1949 (p. 84), reports the use of khellin for bronchial asthma by Dr. Ralph H. Major of Kansas City. The material used by Dr. Major was khellinin, an extract from khellin seeds.

WILLIAM STEINBERG, M.D.

Philadelphia



GLOBIN INSULIN

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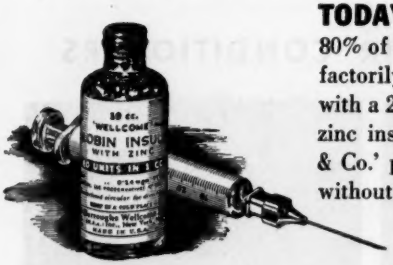
...was developed to fill the "need for an insulin with activity intermediate between that of regular insulin and that of protamine zinc insulin."[1]

IN 1939, Reiner, Searle and Lang described a new "intermediate acting" insulin.

IN 1943, after successful clinical testing, the new substance was released to the profession as 'Wellcome' brand Globin Insulin with Zinc 'B.W. & Co.'

TODAY, according to Rohr and Colwell, "Fully 80% of all severe diabetics can be balanced satisfactorily"[2] with Globin Insulin 'B.W. & Co.'—or with a 2:1 mixture of regular insulin: protamine zinc insulin. *Ready-to-use* Globin Insulin 'B.W. & Co.' provides the desired intermediate action without preliminary mixing in vial or syringe. *In 10 cc. vials, U-40 and U-80.*



'B.W.& CO.'—a mark to remember

1. Rohr, J.H., and Colwell, A.R.: Arch. Int. Med. 82:54, 1948.
2. Ibid Proc. Am. Diabetes Assn. 8:37, 1948.

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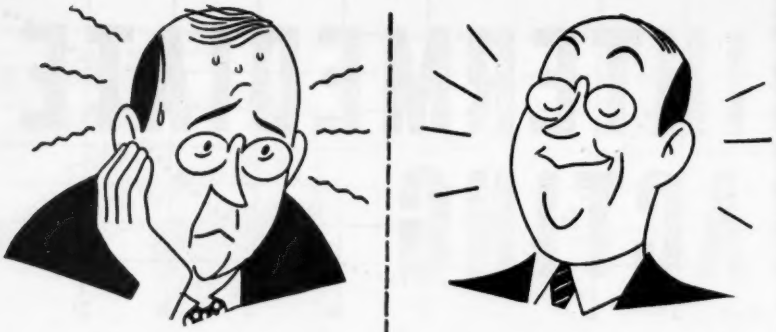

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For offices or rooms up to 400 square feet, your Philco Air Conditioner fits snugly and neatly into the window. Cleanly and simply styled it comes in ivory or soft two-toned brown. For larger offices up to 500 square feet choose the walnut console.

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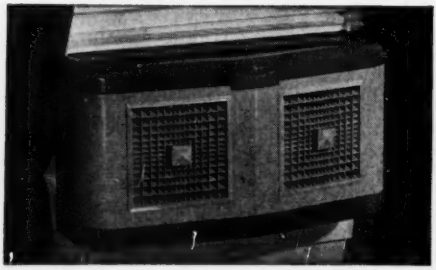
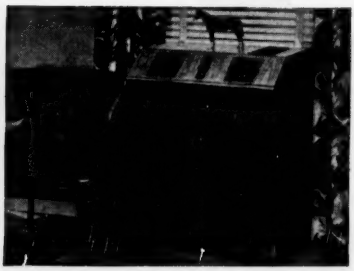




Questions & Answers

All questions received will be answered by letter directed to the petitioner; questions chosen for publication will appear with the physician's name deleted. Address all inquiries to the Editorial Department, MODERN MEDICINE, *84 South Tenth Street, Minneapolis 3, Minnesota.*

QUESTION: A forty-seven-year-old woman has recently discovered very thin hair on the vertex. There are areas suggesting alopecia, especially one very small area in the right temple area near the hair margin. At sixteen, during an appendectomy, the patient's right ovary was removed because of small cysts. She had 2 induced abortions in her twenties, 1 miscarriage in her thirties. Blood and spinal fluid are negative, periods apparently normal. Health is good. I would like advice about treatment, particularly with reference to hormones. Are estrogens recommended?

M.D., Alabama

ANSWER: *By Consultant in Dermatology.* The patient probably has diffuse alopecia resembling the type commonly seen in males. This form not infrequently occurs in women but seldom progresses to an alarming extent. It seems to appear with endocrine abnormalities, particularly at or near the climacteric. Estrogenic therapy apparently helps some of these patients but by no means all. It would not be wise to advise administration without knowing much more about the patient's general condition, especially whether there is other evidence of estrogenic deficiency. If there are indications for the use of estrogens, systemic administration is safer; although estrogens can be used topically, optimum technic and dosage are not yet known. If estrogenic treatment is to be given and the menopause has occurred, there seems no reason why stilbestrol cannot be used. It is certainly the cheapest form. Probably most important is the ability to tell the patient that she is not likely to lose all or most of her hair.

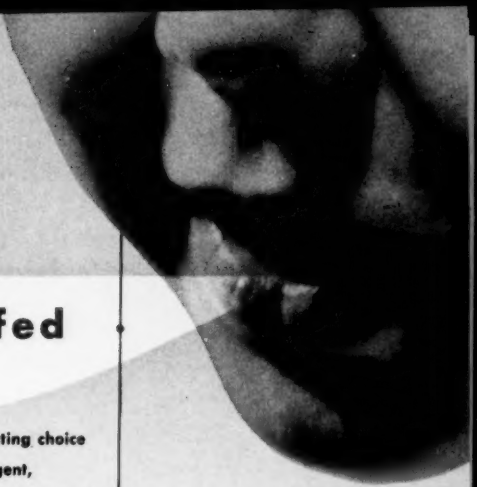
QUESTION: What is the latest treatment for acute infectious mononucleosis? What is the effect of adrenal cortical preparations?

M.D., New York

ANSWER: *By Consultant in Internal Medicine.* There is no specific treatment for acute infectious mononucleosis. The newer antibiotics, such as aureomycin, are being used in the hope of controlling the unknown agent responsible for the disease.

James H. Park, Jr., Baylor University, Houston, Tex., reports very good results from the use of commercial pooled human blood serum. Intravenous injections of 250 cc. daily, given to each of 11 acutely sick children, caused swollen lymph glands and spleen to decrease in size. Abnormal lymphocytes disappeared rapidly, and fever, sore throat, and anorexia subsided.

In the chronic stage, a preparation of adrenal cortical extract had repeatedly produced great improvement. A dose of 2 tablets made from the ex-



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- It's a superior spasmolytic in the most varied manifestations of visceral vagotonia—it suits the youngest, oldest, or the most finicky "taste."
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- It comprehensively combines peripheral and central sedation—for cases of either somatogenic or psychogenic etiology.
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Ethical Pharmaceuticals of Merit since 1878
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FOR WIDELY APPLICABLE READILY ACCEPTED SPASMOLYTIC THERAPY

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therapy

"aim above the mark to hit th[illegible]"

"Err on the side of giving an excess rather than giving too little,"[1] urges Jolliffe on vitamin supplementation. Says Spies: "[Prescribe it] too soon rather than too late."[2] • In one small capsule,

'Robins' Allbee with C delivers the B-factors in two to fifteen times the minimum daily requirement* plus vitamin C in eight times the minimum daily requirement • Unmistakably, Allbee with C provides a ready means for water-soluble vitamin "saturation" therapy.

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each capsule contains:

Thiamine Hydrochloride (B_1)	**15 mg.**
Riboflavin (B_2)	**10 mg.**
Calcium Pantothenate	**10 mg.**
Nicotinamide	**50 mg.**
Ascorbic Acid (C)	**250 mg.**

1. Jolliffe, N.: New York State J. Med. 41:1383, 1941.
2. Spies, T. D.: J.A.M.A. 122:399, 1943.

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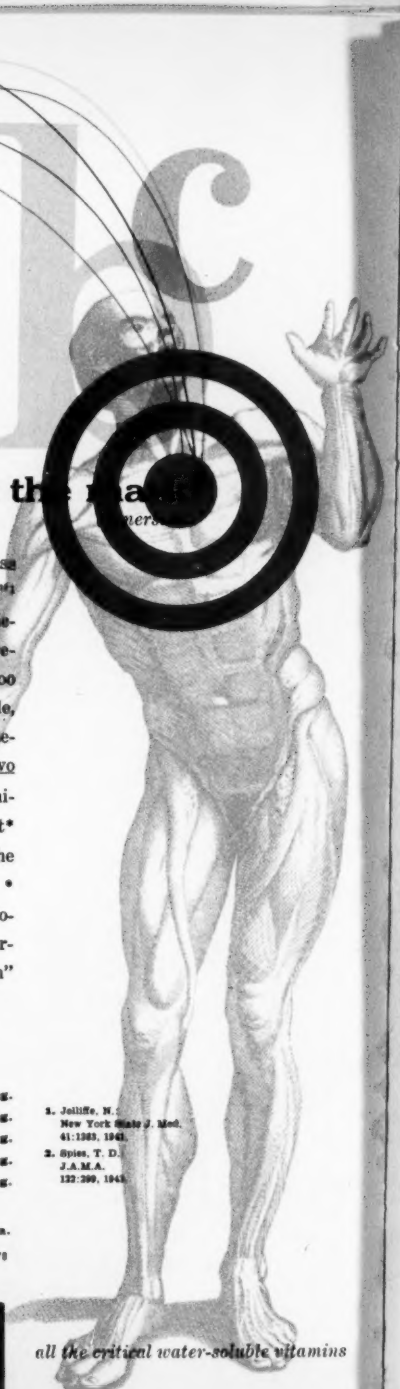
ETHICAL PHARMACEUTICALS OF MERIT SINCE 1878



allbee

all the critical water-soluble vitamins

tract of 10 gm. of adrenal gland should be taken on arising in the morning. Little change occurs at first, but a feeling of well being develops in the second week and is definite in the third. If medication is stopped at this point the benefits usually continue. Occasionally dosage must be increased or a second course given.

QUESTION: I have encountered a few patients with chest symptoms, such as cough, occasional pain, and low-grade fever, who show nothing in sputa but *Monilia albicans*. All have asthmatic type of breathing and tenacious, moderately abundant sputa. In 1 case the fungus culture was *M. parapsilosis*. Is the fungus considered the causative agent when it is the only organism recovered?

M.D., Wisconsin

ANSWER: *By Consultant in Internal Medicine.* Frequently *Candida (Monilia)* are found on the mucous membrane of the skin. Of all the species, only *C. albicans* is reported to be pathogenic. *C. albicans* is harbored in the mouth or throat in 10 to 15% of normal individuals, so demonstration of this fungus does not mean that the disease present is caused by the fungus. The disease is described as causing chronic bronchitis, occasionally a pneumonitis or bronchopulmonary moniliasis. The disease has no characteristic radiologic findings, showing only a nonspecific type of peribronchial thickening. Physical findings are those of chronic bronchitis. A favorable response to potassium iodide is given as evidence that the disease is caused by *C. albicans*. Everyone who has studied this disease has had difficulty in proving the etiologic relation between *Monilia* and chronic bronchitis, even when the bronchitis responds to therapy with potassium iodide.

NEW PYRIBENZAMINE-EPHEDRINE TABLETS

prove highly effective in allergic asthma

FORMULA. Each tablet contains 25 mg. of Pyribenzamine hydrochloride, the most widely prescribed antihistaminic, and 12 mg. of Ephedrine sulfate.

SYNERGISTIC ACTION. It has been shown clinically that "combined Pyribenzamine and Ephedrine therapy was more effective than either drug alone" in terms of intensity of action and duration of effect.[1, 2, 3]

EXCELLENT RESULTS. The combined statistics of investigators show that 70 to 75% of asthma cases are improved by administration of Pyribenzamine-Ephedrine Tablets. This new combination controls the characteristic cough and wheezing especially in children who develop asthmatic symptoms during the course of respiratory infections.

Pyribenzamine-Ephedrine is also remarkably effective in patients who develop asthma in conjunction with allergic rhinitis since this combination tends to promote decongestion of the entire respiratory tract, including the nasopharyngeal mucosa.

Use of Pyribenzamine-Ephedrine between asthmatic attacks usually lengthens the interval between acute episodes.

FEW SIDE EFFECTS. The side effects noted have been occasional irritability due to the ephedrine; drowsiness which has occurred in 5 to 7% of cases; and nausea with similar frequency. Very seldom are side effects so severe as to require the withdrawal of this therapy.

Forensic Medicine

COMPILED BY ARTHUR L. H. STREET, LL. B.

PROBLEM: Can a county hospital adopt valid rules restricting the right to practice medicine and surgery in the hospital?

COURT'S ANSWER: Yes. But the rules must be such as are reasonably essential for the protection of patients.

A decision of the Indiana Supreme Court on this question (Mar. 14, 1949) supersedes and in part reverses a decision of the lower Indiana Appellate Court (Oct. 22, 1948). The gist of the Supreme Court's decision is as follows:

Despite an Indiana statute which gives county hospital patients a right to engage their own physicians, subject to reasonable rules, a rule may be enforced requiring that practitioners be members of the hospital's resident staff. But a rule restricting staff membership to those recommended by the staff is unreasonable. The Supreme Court refused to follow a precedent set by the Illinois Appellate Court (316 Ill. App. 455, 45 N. E. 2d 329) in ruling that new membership on a public hospital staff may be limited to practitioners invited by the staff.

The Indiana Supreme Court also condemned a rule limiting staff membership to members of the county medical society, as virtually delegating to the society the right to determine who should serve on the staff. But the court upheld a rule requiring a surgeon not a member of the staff on a certain date, not only to be a licensed physician but to have served one year as an intern in an approved hospital and to have had three years of surgical training of the kind approved by the American College of Surgeons. On that point, the Indiana Supreme Court followed the reasoning of the Florida Supreme Court, "that a license to practice medicine does not guarantee that the holder thereof is capable of doing surgery."

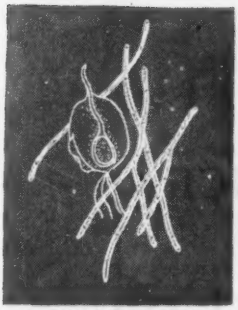
The foregoing conclusions led the Indiana Supreme Court to decide that a particular practitioner was properly refused permission to practice surgery in defendant county hospital, but that he was entitled to practice medicine there (84 N. E. 2d 469).

PROBLEM: A doctor sued on notes given by a patient's husband as advance payment for services. The husband defended the suit on the ground that the doctor had guaranteed that he would cure the defendant's wife of a mental disorder but had failed to do so. Was defendant bound to produce expert testimony to prove that the guaranty had been broken?

COURT'S ANSWER: No.

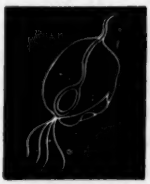
The Texas Court of Civil Appeals, Ft. Worth, decided that although malpractice must be established by competent evidence, that is, expert testimony, a lay witness may testify to the general condition of persons with whom he is acquainted and associated frequently.

(Continued on page 40)



DUAL INFESTATION

MONILIA



TRICHOMONAS

specific for vaginal trichomoniasis

"All patients became symptom-free and bacteriologically negative..."[1]

now effective in moniliasis

"Symptomatic cure was effected in about 80% and mycologic cure in about 50%..."[2]

AVC (Allantomide Vaginal Cream) has long been accepted by clinicians as specific for the treatment of vaginal trichomoniasis. Investigators have unanimously reported it effective in 98-100% of cases.

With the addition of 9-aminoacridine, a new, potent antiseptic agent, AVC IMPROVED is capable of effecting mycologic cure in moniliasis.[2] Thus, AVC IMPROVED may be expected to provide relief in those stubborn cases of vaginitis which are due to mixed infections.

Available in 4 oz. tubes, with or without plastic applicator.

1. *Horoschak, A., and Horoschak, S.: Jl. Med. Soc. N. J., 43:92, Mar., 1946.*
2. *Dill, L. V. & Martin, S. S.: Med. Ann. Dist. Col., 17:389, July, 1948.*

AVC IMPROVED

ALLANTOMIDE VAGINAL CREAM with 9-Aminoacridine

THE NATIONAL DRUG COMPANY, PHILADELPHIA 44, PA.

Manufacturers of

Pharmaceutical, Biological and Biochemical Products for the Medical Profession

Controlled Study

CONFIRMS IMPORTANCE OF

Morning Meal

A study* recently concluded at the Departments of Physiology and Nutrition of the college of medicine at a distinguished university established that the value of an adequate breakfast, as recommended by nutrition authorities, is definitely reflected in maximum work output and mental acuity during the prenoon hour.

It also demonstrated that the long continued omission of breakfast detrimentally affects maximum work output, simple and choice reaction time, and neuromuscular tremor.

Under adequately controlled conditions data were collected on the effects of four different breakfast habits on the maximum work output, mental acuity, and neuromuscular tremor of six young women ranging from 22 to 27 years in age. The breakfast habits investigated constituted habituation to an 800 calorie breakfast, effects of which were considered the critical standard, to no breakfast, to coffee only (1 cup of coffee, 1 ounce of cream, no sugar), and to a 400 calorie breakfast.

*Reprint of the study referred to will be sent on request.

From the data gathered the following conclusions were reached:

1. When "no breakfast" was the morning habit, maximum work output showed a significant *decrease*, while a notable *increase* resulted in simple and choice reaction time and in tremor magnitude.
2. Habituation to coffee only showed a similar *decrease* in maximum work output, with corresponding *increase* in reaction time and in tremor magnitude.
3. When habituation to the 400 calorie breakfast was accomplished after the "coffee only" period, a significant *increase* over the findings in the "coffee only" period in maximum work output resulted and both simple and choice reaction time as well as muscle tremor magnitude showed a noteworthy *decrease*.

The authors point out that no direct comparison could be made of the physiologic responses during the 400 calorie and 800 calorie breakfast periods, because the breakfast period of "coffee only" occurred between the 800 calorie and 400 calorie periods.

This controlled investigation now provides experimentally established support for the widely advanced admonition "Eat an Adequate Breakfast." For, though the authors do not draw this conclusion, it may well be reasoned inversely that maximum work output should be increased, and mental acuity improved, when faulty breakfast habits are replaced by the eating of an adequate morning meal.

The court noted that ordinarily a physician never insures results but simply undertakes to use reasonable skill, care, and judgment, measured by professional standards. But the courts have frequently decided that a doctor may bind himself by a contract guaranteeing a cure or to make no charge for services not resulting in a cure.

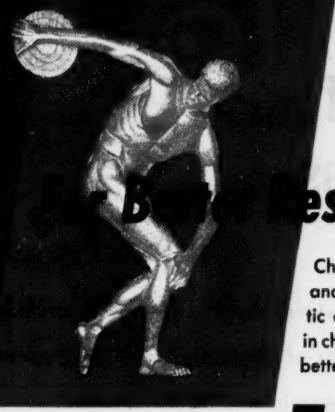
The court also decided that if the doctor partly performed his contract he was entitled to collect the reasonable value of his services, less any damages sustained by the patient through the doctor's failure to fulfill his contract (215 S. W. 2d 356).

PROBLEM: Can a state medical board determine, without the evidence of expert testimony, whether a practitioner against whom charges are presented has been guilty of professional misconduct or is competent to practice?

COURT'S ANSWER: Yes.

Noting that members of the Connecticut board are physicians appointed on recommendation of the Connecticut Medical Society, the Supreme Court of Errors of that state declared that it would presume, even if it did not know, that the members of the board were qualified to decide whether the conduct of a physician so derogated from professional standards as unreasonably to jeopardize public interest.

However, the court added that, although it was not necessary that expert testimony on the point be produced before the board, "the person under charges has the right to offer expert opinions at the hearing before the board; it is bound to admit such evidence; and it would be obliged to consider it in arriving at its conclusions" (64 Atl. 2d 330).



Better Results in Arthritis

Choice of an effective antirheumatic agent and close supervision during the therapeutic effort constitute rational management in chronic arthritis. With this plan of attack, better results may be anticipated.

ERTRON®

STEROID COMPLEX, WHITTIER

1. With Ertron therapy, improvement, both locally and systemically, has been reported in 701 out of 852 arthritic patients (82.2%). In a disease as resistant to treatment as rheumatoid arthritis, this result is striking.[1] "Subjectively . . . generally improved systemic condition, increased muscular tone and less fatigue, pain and stiffness. . . . Objectively, less swelling and increase in weight, functional activity and joint mobility. . . ."[2]

2. Ertron is effective primarily in chronic arthritis of the rheumatoid type. It is not indicated in patients suffering from kidney damage.

3. Observation of the patient at reasonably frequent intervals demonstrates the consistent arthrokinetic influence of Ertron and, at the same time, serves to control any untoward reactions that might appear. These are rare[3]; marked intolerance requiring cessation of therapy occur in only 1.4% of patients, while minor side effects, mainly gastro-intestinal, may be encountered in about 8% of patients. "These mild digestive disturbances disappear almost immediately after the cessation of Ertron administration and usually do not recur when this therapy is again instituted."[4]

BIBLIOGRAPHY

(1) Magnuson, P. B.; McElvenney, R. T., and Logan, E. E.: J. Michigan M. Soc. 46:71,1947.
(2) Snyder, R. G., and Squires, W. H.: New York State J. Med. 40:708, 1940.
(3) Cohen, A., and Reinhold, J. C.: Indust. Med. 17:442, 1948.
(4) Farley, R. T.; Spierling, H. F., and Kraines, S. H.: Indust. Med. 10:341, 1941.

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New hematinic for treatment of nutritional anemias

Gluferate Tablets supply two key factors needed for treatment of chronic or refractory anemias: iron and glutamic acid hydrochloride.

The iron, for hemoglobin regeneration, is ferrous sulfate . . . effective in smaller doses than most other therapeutic forms of iron. The glutamic acid hydrochloride is in adequate amount to promote iron absorption and correct hypoacidity.

Recommended daily dose of Gluferate is 6 Tablets—furnishing 12 grains exsiccated ferrous sulfate and 1.2 Gm. glutamic acid hydrochloride. Gluferate tablets are supplied in bottles of 100's.

Tablets

GLUFERATE®

Ferrous sulfate and glutamic acid hydrochloride

Wyeth Incorporated, Philadelphia 3, Pa.

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Special Article

How Is the British Doctor Getting Along?

VICTOR COHN

The first of two articles prepared for Modern Medicine

To write this report for MODERN MEDICINE, *Mr. Cohn spent five weeks in England and Wales. This article with the one to follow on July 15 gives a firsthand account of the British doctor's experience. Mr. Cohn is an able science writer for the* Minneapolis Tribune. *Before going to England he spent several months studying U. S. health insurance proposals. Overseas he talked to doctors and patients from all economic groups. He brings no "message," he takes no sides, but he does give the essentials to an understanding of the English medical revolution—the findings of a keen observer against a backdrop of historic British economic policy.*

SOCIALIZED medicine has come to Britain to stay.

Most doctors, though displeased with what they consider low pay and long hours, say "it was needed." The average workingman is getting more medical service than ever; many of the titled, too, are on the doctors' health service lists. Private patients have dwindled to a handful from the upper middle class and the well to do.

The burden is hard for the health service's 21,000 family doctors—the men who comprise the service's backbone. Their skill and morale are under real strain. Britain's good GP's, like America's, were accustomed to being counselors and friends as well as, or as part of, being physicians. Today, most find few moments for such time-consuming attention, so heavy is the public's demand for treatment, prescriptions, and a host of certificates.

The pent-up demand shows plainly why socialized medicine was inevitable, even though facilities and manpower to serve it are sketchy. For years Britons suffered bad teeth, Woolworth eyeglasses (or hand-me-downs), and fierce inequality not only in standards of medicine but also in nutrition and housing.

World War II, otherwise no blessing, gave each Briton "fair shares"—efficient, honest rationing of scarce food, clothing, and shelter. Britons stood patiently in line for their rations, both of food and of equally scarce medical care from their busy home-front doctors.

The people not only liked this but they voted for more. In 1945, they swept out Winston Churchill and elected a Labor government—a government of socialists—by one of the heaviest majorities in British history. Labor was pledged to carry out the war-born Beveridge plan—social security, cradle to coffin. A national health service was a basic assumption. Conservatives, too, had supported the plan but failed to stress it as strongly as Labor.

The health service, even then, was not new to Britain. In 1911 Lloyd George's Liberal government had enacted workmen's medical insurance on a compulsory, contributory basis. Lloyd George's plan started modestly but eventually grew to cover all manual workers and all others earning under $1,680 a year, altogether 44% of the population. The plan never covered dependents, however, and never provided comprehensive hospital and specialist service or expensive appliances.

The British Medical Association fought Lloyd George in 1911 and, although unsuccessful, did win free choice of doctor and local administration. Within a few decades even the BMA was asserting that "everybody who wants should be able to get a complete health service without having to pay a doctor's bill." In 1929 the BMA proposed that the Lloyd George plan be extended to dependents. By depression-weary 1938 the BMA was outlining "a general medical service for the nation," with specialist, hospital, nursing, and dental service.

For years Britain's doctors chewed over national health plans, and read each other's views—of Conservative, socialist, and several nonpolitical hues—in the democratic, free-for-all letter columns of the *British Medical Journal* (BMA's organ) and the independent *Lancet*. Need was hardly an issue; the debate was on method.

The BMA and the Conservative party fought Labor's health plan. BMA objections centered on the fear of a salaried service. Labor Health Minister Aneurin Bevan—pugnacious socialist who snapped that doctors "must bend the knee to the will of the British parliament and the British people"—was accused of proposing a $1,200-a-year basic salary for all doctors as the thin edge of the wedge toward a full salaried service.

Labor's health plan, however, was enacted in 1946. July 5, 1948 was the date it was to go into effect. In the spring of 1948 Bevan offered a compromise to organized medicine's appointed negotiators: [1] a promise to seek an amending bill preventing a health minister from decreeing a salaried service without parliament's sanction, [2] full payment in capitation fees for most general practitioners, [3] the basic salary, plus lower capitation fees, for young men in their first three years of practice and others with small practices who might choose it. The BMA considered that the capitation fee at least left reward in the hands of patients, not officials.

The BMA's council began a plebiscite of all doctors. The council recommended a "no" vote on the ground that liberties were still endangered by other provisions, but warned that unless 13,000 general practitioners pledged to stay out of the government service, a successful fight was impossible. GP's had thundered an overwhelming "no" in two earlier plebiscites, but now:

► They had been mellowed somewhat by the Bevan concessions.

► More important, all but 1,000 drew an average 40% of their incomes from workmen's insurance panel patients. This plan was to end July 5.

► Most important, the new law abolished the traditional buying and selling of practices and offered compensation bonds, $5,000 to $6,000 worth, *only to those who joined by July 5.*

This time only 9,588 GP's voted to stay out; 8,639 said they would serve. However, doctors of all types still disapproved of the plan 25,842 to 14,620, though here, too, more approved than in previous ballots. The BMA's governing council ended the battle and recommended cooperation. "The fight is over," said Dr. H. Guy Dain, chairman. "The public after July 5 will get the very best that doctors can give."

Many doctors cried "shameless surrender," and almost all

"I had such a lovely dream last night. I was having my hair permed FREE under the National Health."

"But you can hardly expect the Health Service to pay for it if you really DO intend to use it as a weed-killer."

National Health Service Target for *Punch's* Barbs

The first anniversary of Britain's National Health Service falls on July 5. On that date the controversial "cradle-to-the-grave" program will have been in operation just one year. During that time the program has been, as the *New York Times* puts it, "the subject of much vigorous praise, violent denunciation, and cold-eyed analysis." Few Britons are neutral. However, some features of the program have proved irresistible to social satirists and have invited the tartly humorous attention of *Punch*. In the cartoons reproduced on this and the facing page are *Punch's* notions of a few of the laughable situations arising from the service's operations, together with some whimsical suggestions for additional benefits which might make the program even more attractive.

"But I want them for knitting."

"Is there a doctor in the house who has joined National Health Scheme, and has a vacancy on his list?"

"Anyone seen me National 'Ealths?"

called the "join by July 5 or no compensation" edict a "black jack." But at least 90% quickly enrolled.

Six months later the *Lancet* was to comment:

> On July 5 the biggest operation ever known in medicine was performed. It was an attempt to bring the many separate medical services of this country into a single integrated system which should eventually meet all needs. Like other major operations, it has had some alarming immediate results; but its ultimate consequences cannot be foretold this early . . . In so vast an operation mistakes were inevitable, and many of them can still be rectified. . . . It is probably fair to say that the service is going on as well as could reasonably be expected—and in some respects rather better.

What happened July 5? Health Minister Aneurin Bevan took direct control over all hospitals (except a few hundred, mostly Catholic), over their specialist staffs and other employees, a national blood bank network, and bacteriologic laboratories. The hospitals were grouped under regional boards, only the teaching hospitals keeping their old boards of governors. Specialists, some 5,000, became either full- or part-time salaried staff members. Except in small towns, GP's do not serve on hospital staffs.

Local executive councils—138 in England and Wales—took direction of the family doctor service, plus dentists and chemists (British for druggists). Each council has 25 volunteer members: 12 named by local medical, dental, and chemists' committees, 8 by the local county government, and 5 by the health minister.

Local and county governments directed many services, such as those of midwives, who deliver most babies in Britain, maternal and infant health clinics, home nursing, ambulance service, and domestic help.

Every Briton who wished to enrolled with a general practitioner; 95% of the population of 50,000,000 soon signed up.

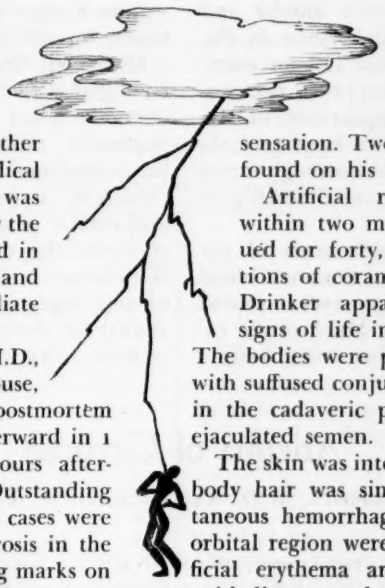
A head of family enrolls for himself and dependents. He picks his own doctor and can change any time that he likes. And the doctor is generally free to accept him or not as a patient. Away from home, Mr. Patient can present his medical card and get treatment from any health service doctor.

He usually visits the doctor at his office, waiting his turn, but is entitled to home care when needed. He can get, at the chemist's shop, any medicines and drugs the doctor prescribes, no

(Continued on page 102)

Effects of Lightning

MAJ. M. J. G. LYNCH AND MAJ. P. H. SHORTHOUSE*
Royal Army Medical Corps, England



DURING an army soccer game, forked lightning struck in the midst of the teams, killing 2 players and injuring another and the referee. Medical officers, one of whom was in attendance and saw the bolt, were on the field in a matter of seconds and observed the immediate effects.

M. J. G. Lynch, M.D., and P. H. Shorthouse, M.D., also present postmortem findings six hours afterward in 1 case and fourteen hours afterward in the other. Outstanding features of the 2 fatal cases were hemorrhages and necrosis in the pancreas and lightning marks on the exterior of the bodies.

The men nearest to the bolt were struck to the ground at once; the others fell but soon got to their feet. Neither of the 2 injured men saw the flash, though within 5 and 10 yd. of the strike. Each was in shock, and was cold and clammy. Pupils were dilated and pulse was rapid with poor volume.

The player lost consciousness for about two minutes shortly after the strike and could not speak for half an hour. The referee had flaccid paralysis of one arm and of both legs; within sixteen hours, motor power gradually returned, preceded by the return of sensation. Two small burns were found on his feet.

Artificial respiration, begun within two minutes and continued for forty, intracardial injections of coramine, and use of a Drinker apparatus evoked no signs of life in the 2 other men. The bodies were pulseless and livid, with suffused conjunctivae and pupils in the cadaveric position. Both had ejaculated semen.

The skin was intensely cyanotic and body hair was singed. Small subcutaneous hemorrhages in the circumorbital region were noted and superficial erythema and denudation of epithelium on the right sclera and cornea of one body, on the left sclera and cornea of the other. Distinct cutaneous arborescent marks appeared on the neck and chest of both, with smaller marks over the upper thigh.

Internally, the great veins were considerably engorged. Blood had extravasated in the region of the sternomastoid muscles. Hemorrhage was diffuse into the caudal two-thirds of the pancreas, with dark discoloration of the adjacent organs. Superficial hemorrhages and generalized congestion of the lungs were noted.

* Injuries and death from lightning. Lancet 256:473-478, 1949.

The spleens were greatly congested and twice normal size. The livers, suprarenal glands, and kidneys appeared normal, although congested. Both brains showed scanty minute hemorrhages.

In each pancreas histologic examination showed massive lobular and multilobular necrosis, chiefly in the tails. Hemorrhage was not an essential part of the pancreatic necrosis. The coagulative appearance of the necrosis and occasional large gas bubbles seen in the hemorrhagic areas indicate that heat caused some part of the damage.

In the hemorrhagic areas of the lungs, the alveoli and the small blood vessels and capillaries were ruptured in numerous places. Much of the extravasated blood was fused into a hyaline eosinophilic mass with some red-cell ghosts apparent.

Significant findings in the brain tissues were hemorrhages from 2 or 3 mm. to microscopic perivascular extravasations in the floors of the fourth ventricles and in the suprachiasmatic regions. Congestion was severe in both brains but no edema was noted.

Nissl body findings were considered significant only in the autopsy done six hours after death. Various degrees of tigrolysis were found in the cerebellum, olivary bodies, suprachiasmatic region, caudate nucleus, and orbital cortex. The striking feature was the extreme patchiness of the change, with no spatial pattern of cell degeneration. Findings were similar to those observed in brains of heat stroke victims.

Anemia of Cirrhosis

THOMAS JARROLD, M.D., AND RICHARD W. VILTER, M.D.*

MACROCYTIC anemia associated with chronic hepatic disease is the result of a metabolic defect different from that which causes pernicious anemia. Treatment with liver extract or folic acid fails to induce hematologic response.

Thomas Jarrold, M.D., and Richard W. Vilter, M.D., of the University of Cincinnati find that examination of the peripheral blood of patients with portal cirrhosis and macrocytic anemia reveals moderate macrocytosis but not poikilocytosis, anisocytosis or hypersegmented polymorphonuclear leukocytes characteristic of pernicious anemia. Bone marrow is normoblastic with a consistent increase in the percentage of plasma cells roughly proportional to the degree of hyperglobulinemia of the blood.

Of 30 patients with chronic liver disease, 20 had macrocytic anemia. Liver extract or folic acid brought hematologic response in only 3, all of whom had been eating foods grossly deficient in extrinsic factor.

* Hematologic observations in patients with chronic hepatic insufficiency: sternal bone marrow morphology and bone marrow plasmacytosis. J. Clin. Investigation 28:286-292, 1949.

Uses of Intravenous Procaine Therapy

DAVID J. GRAUBARD, M.D.
New York Post-Graduate Medical School, New York City
MILTON C. PETERSON, M.D.*
Research Hospital, Kansas City, Mo.

MANY painful conditions of traumatic, inflammatory, or spastic type are greatly benefited by intravenous injection of procaine hydrochloride. Symptoms disappear, joint mobility increases, skin temperature improves, swelling and cyanosis subside.

During a single year, 1,954 infusions were given in 448 cases with no

TABLE 1. TRAUMATIC CONDITIONS

Type	*No. of cases*	*Average no. infusions*	*Results*
Fracture	61	2	Relief of pain, decrease in edema, early mobility. Some evidence of early healing. Insufficient anesthesia for reduction.
Postdislocation arthralgia	17	3	Relief of pain, increase in mobility. Shorter period of disability.
Sprain	19	1	Immediate relief of pain, increased mobility. No "after pains."
Traumatic arthritis	12	4	Relief of pain. Increase in mobility depends on pathologic changes, deformity, and duration of symptoms.
Myofascitis	44	4	Relief of pain, early mobility. More effective in low back pain. Myalgia of upper back responds better to local infiltration.
Herniated intervertebral disk	22	2	Useful in differential diagnosis. No change in symptoms.
Postoperative pain	14	3	Relief of pain. Better convalescence.
Reflex sympathetic dystrophy	33	3	Relief of symptoms. Good results obtained in phantom limb.
Laceration and contusion	2	1	May be used as substitute for general or regional anesthesia.
Total	224		

* The therapeutic uses of intravenous procaine. Anesthesiology 10:175-187, 1949.

harmful reactions (see tables). The drug is analgesic, sympathicolytic, vasodilating, and secondarily parasympathetic and anticontracting.

David J. Graubard, M.D., and Milton C. Peterson, M.D., were able to benefit almost every traumatic case, the exception being pain due to herniated intervertebral disk.

For arthritis, procaine with vitamin C appears more effective than other methods, although treatment is still experimental. Importance of the vitamin can hardly be overestimated.

Spastic states of neurologic origin are more efficiently relaxed by procaine than by curare. Total dose at any one time never exceeds 4 mg. per kilogram of body weight, given in a period of twenty minutes.

TABLE 2. INFLAMMATORY CONDITIONS

Type	*No. of cases*	*Average no. infusions*	*Results*
Rheumatoid arthritis	13	14	Relief of pain, increased mobility, decrease in flexion contractures. Intensive therapy in conjunction with vitamin C indicated.
Osteoarthritis	91	5	Relief of pain, increased mobility. Vitamin C therapy indicated in many cases.
Neuritides	40	3	Of no value in tic douloureux. Relief of burning pain in herpes. Marked relief of pain in neuritis.
Vascular diseases			
Coronary disease	2	7	Relief of pain in angina of effort.
Thrombo-angiitis obliterans	5	3	Temporary, transient relief of pain.
Arteriosclerotic gangrene	1	1	Used preoperatively for relief of pain.
Trench foot	1	2	Improved circulation, skin temperature. Relief of pain on walking.
Diabetic gangrene	1	12	In incipient cases may prevent gangrene. Relief of pain.
Postcerebral accident	1	10	Increases mobility and coordination.
Arterial spasm associated with embolus	2	4	Prognostic aid; helps overcome shock and arterial spasm.
Chronic lymphedema	2	7	Equivocal.
Thrombophlebitis	13	4	Relief of pain, spasm, erythema, and edema.
Bursitis	18	5	Relief of pain, early mobility.
Tuberculous spine	1	2	No change in symptoms.
Dermatitis	3	6	Temporary, transient relief of pain and itching.
Total	194		

TABLE 3. MISCELLANEOUS CONDITIONS

Type	*No. of cases*	*Average no. infusions*	*Results*
Malignancy	4	4	Temporary, transient relief of pain. May be used as substitute for morphine.
Postanterior poliomyelitis	4	6	Relief of vasomotor disturbances. Improved coordination in spastic types.
Congenital spasticity	8	25	Improved coordination, relaxation, diminution in spasm. Upper extremity spastics not as much benefited as lower extremity spastics.
Paralysis agitans	4	8	Improvement in coordination, diminution in rapidity and amplitude of tremors.
Multiple sclerosis	2	9	No apparent value.
Amyotrophic lateral sclerosis	1	10	No apparent value.
Scleroderma	1	7	Relief of pain for three months.
Pruritus (Hodgkin's disease)	1	11	Transient, temporary relief of itching.
Postoperative anuria	2	1	Almost immediate diuresis.
Serum sickness	3	1	Relief of itching and urticaria.
Total	30		

THYMOL TURBIDITY may be considered, not as a specific test of liver function, but as an indicator of changes in the serum proteins in consequence of different virus infections, declare Kurt Iversen, M.D., and Flemming Raaschou, M.D., of Copenhagen. At Frederiksberg Hospital, Copenhagen, MacLagan's thymol turbidity test was employed in study of 373 patients with different acute infectious diseases. Reactions were positive in 71% of the patients with measles, 73.5% of those with infectious mononucleosis, and 75% of the ones with acute infectious hepatitis. Results were negative with tonsillitis, scarlet fever, mumps, serous meningitis, pneumonia, purulent meningitis, tuberculous meningitis, and acute gastroenteritis. The thymol test is possibly of practical importance for distinguishing measles from other kinds of morbilliform eruptions.

Arch. Int. Med. 82:251-262, 1948.

Glycine for Peripheral Vascular Disease

J. R. GUSTAFSON, M.D., K. N. CAMPBELL, M.D., B. M. HARRIS, M.D., AND S. D. MALTON, M.D.*

University of Michigan, Ann Arbor

THE amino acid, glycine, taken orally, increases blood flow through the extremities by causing vasodilation and is helpful in the conservative management of peripheral vascular insufficiency.

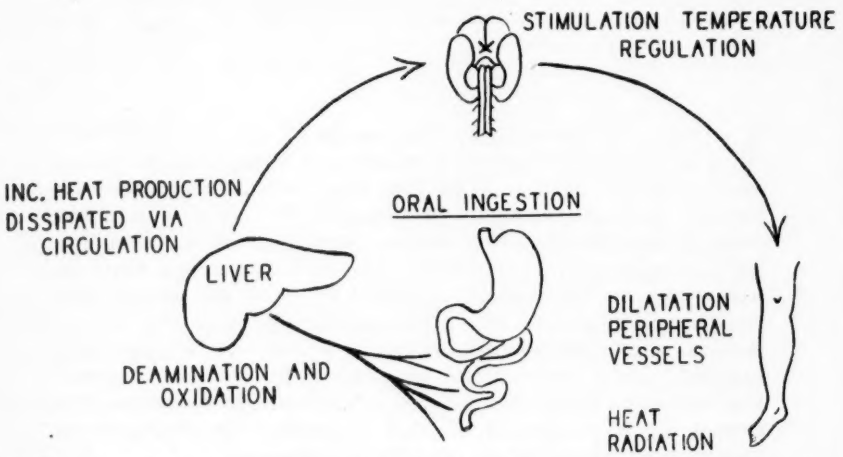
After absorption from the gut (see illustration), glycine is broken down and oxidized in the liver. These biochemic reactions produce an excess of heat which is dissipated in the circulatory system.

Effect of the excess heat on the temperature-regulating center in the hypothalamus stimulates prolonged vasodilation in the limbs. By spacing glycine administration vasodilation is almost constant.

J. R. Gustafson, M.D., K. N. Campbell, M.D., B. M. Harris M.D., and S. D. Malton, M.D., include the use of glycine for conservative treatment of patients with arteriosclerotic peripheral vascular disease, Buerger's disease, Raynaud's disease, and Raynaud's phenomenon.

A dose of 20 gm. dissolved in 200 cc. of fluid is given orally two or three times daily. No untoward reactions have been observed. Occasional nausea may be avoided by taking the glycine after meals. Because of the very sweet taste glycine is usually given in milk, coffee, or fruit juice to make it more palatable.

Complete abstinence from tobacco



* The use of glycine in the treatment of peripheral vascular disease. Surgery 25:539-546, 1949.

is required. The patient is instructed in the Buerger-Allen postural exercises and the proper care of the affected limb. Local or systemic infections should be treated in the usual manner.

Hospitalization is recommended for severe disease but most patients may be managed by weekly visits to the office or clinic.

The regimen is most successful with Buerger's disease. Results are encouraging but less remarkable with Raynaud's disease or peripheral arteriosclerosis, especially when advanced to the stage of ulceration or gangrene.

Penicillin Injection of Carbuncles

THOMAS H. BATE, M.D.*

THE pain of a carbuncle is relieved promptly and infection rapidly checked by local injection of a solution containing penicillin and novocain. Thomas H. Bate, M.D., of Phoenix finds the method especially helpful for boils associated with diabetes, nephritis, or other debilitating conditions.

Treatment may be applied in the office or home. No reactions occurred among 20 cases involving large areas of the neck, lips, hands, buttock, thigh, and abdomen.

For the injections, penicillin is mixed with 5 to 20 cc., as required, of 2% solution of novocain in a concentration of 100,000 units per cubic centimeter. A 24- or 26-gauge hypodermic needle and a lock type of syringe are employed.

As illustrated, the zones of a carbuncle include a central necrotic drainage area (*a*), surrounded by a bluish congested region (*b*), and an outer indurated ring (*c*). The skin beyond the indurated portion is carefully cleaned. A small wheal (*d*) is first made in relatively healthy tissue and other sites are infiltrated around the carbuncle. When completed, the wheals should be continuous.

Hot packs are beneficial. Drainage is profuse on the second day and continues two or three days longer. The defect heals quickly with a thin, white, nonadherent scar, and induration resolves in two to four weeks.

* The treatment of carbuncles by the local injection of penicillin. Ann. Surg. 129:494-498, 1949.

CHRONIC GRANULOMA INGUINALE should be treated with relatively large amounts of streptomycin. The disease did not recur among 19 patients given 20 gm. of the antibiotic in 0.5-gm. doses every three hours for five days, but did recur in 1 of 4 patients given a total of only 10 gm. Pain disappears in thirty-six hours, healing begins in two to four days, and is complete in two to six weeks, although residual induration may continue for six months in severe cases, state M. Harriss Samitz, M.D., and associates of the University of Pennsylvania, Philadelphia. Surgical removal of hypertrophied labia was necessary four months after therapy in 3 women because of failure of involution. Except for transient impotency in 2 men, no manifestations of toxicity from high dosage of streptomycin were apparent.

J. Invest. Dermat. 12:85-93, 1949.

EPIDERMOPHYTOSIS, athlete's foot, may be checked by application of an odorless ointment containing 0.05% phenylmercuric nitrate. Irritation is relieved at once, lesions heal in ten to fourteen days, and no complications occur. Thickened skin must be removed before the fungicide is used. Body secretions do not affect action of the ointment. J. B. Adamson, M.B., of Newcastle-upon-Tyne and W. Gillies Annan, M.D., of Durham County, England, found that spread of epidermophytosis can be controlled in public showers if bathers wash and dry feet carefully, especially between the toes, and phenlymercuric nitrate ointment is applied in all suspected cases. Foot sandals are advisable for walking between showers. Daily treatment with mild fungicides is preferable to occasional treatment with strong preparations.

Brit. J. Phys. Med. 12:34-37, 1949.

ACNE VULGARIS often yields to treatment with a sulfur compound when a vehicle containing active agents is used to enhance percutaneous penetration. Good to excellent results were obtained in 10 of 12 patients who completed three months of prescribed treatment with such a preparation, intraderm sulfur, report Maurice J. Strauss, M.D., and Harry Sigel, M.D., of Yale University, New Haven. The medication is massaged into the skin for two minutes in the morning and for thirty minutes before bedtime. The morning application is made after washing with soap, is allowed to stay on for fifteen minutes, and is then removed with a towel. The evening application is left on all night. Mild desquamation is desirable. If desquamation becomes excessive frequency of application is decreased.

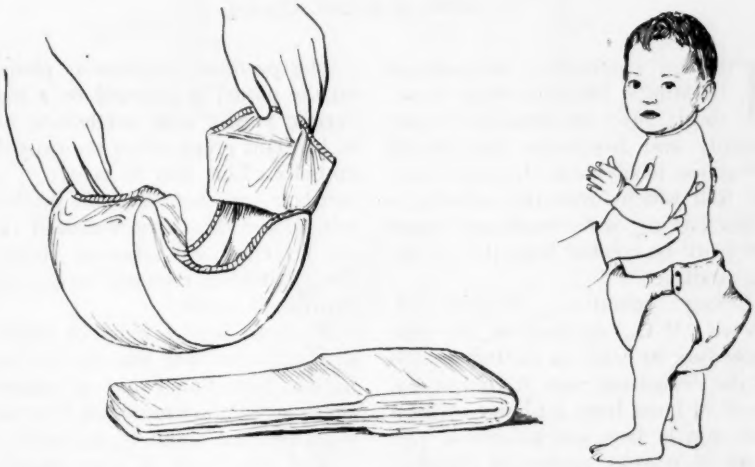
Connecticut M. J. 13:100-103, 1949.

An Improved Diaper

CHARLES F. McKHANN, M.D., AND GEORGE BRICMONT*
Western Reserve University, Cleveland

THE unhygienic and impractical aspects of diaper design have often been deplored by pediatricians, but diapers still follow a pattern devised in some remote era of civilization.

Now a new arc-shaped, waterproof-lined nylon container holding a disposable pad seems to answer many problems.



The garment collects urine and stool with minimum contamination of the baby's body or the bed or clothing.

The inside ends of the envelope, in contact with the baby, are pocketed. Only a small area in the middle of the pad is directly exposed to the excretions, and the shape of the diaper holds this center section away from the baby.

The pad is pocketed and of double thickness in front to absorb sudden expulsion of urine. The diaper rests high on the abdomen, extending only a little over the buttocks, and is fastened over the hips with pins.

The pad is removed by grasping the ends of the container, turning it inside out, and applying pressure to the middle with the thumbs. The folded pad falls out without touching the fingers.

Charles F. McKhann, M.D., and George Bricmont find that incidence of skin rash and intertrigo is decreased by use of the improved diaper. No discomfort is observed in infants lying

* The baby's diaper with suggestions for its improvement. J. Pediat. 34:131-138, 1949.

on face or back. Babies sleep longer and more soundly than with conventional diapers.

No odor is detectable, even in hospital nurseries housing up to 12 infants. Bed linen is seldom soiled and laundry is materially reduced.

For children in casts, the device eliminates the need for frequently changing soiled casts.

Use of this new diaper should reduce the high incidence of simple pyuria among infant girls and the spread of gastrointestinal disease by stool-contaminated fingers of mother or nurse.

Correction of Protruding Ears

ADOLPH M. BROWN, M.D.*
University of Illinois, Chicago

THOUGH a relatively insignificant deformity, lop ears often so seriously affect an individual's personality and happiness that plastic correction is advisable. In most cases, the fold which forms the anthelix is either lacking or flattened and a new one must be created from the auricular cartilage.

Before operation, Adolph M. Brown, M.D., determines the best procedure by trial on rubber models of the disfiguring ears. A rubber ear, made of latex from a plaster of paris cast, may be bent and sutured at will. Type of incision, amount of ellipse to excise, and fixation by suturing aural cartilages back to back (Fig. *a*) or by plication (Fig. *b*) are planned.

The operation is performed with the patient supine and head turned to one side. The proposed anthelix is outlined in methylene blue on the anterior of the ear. Anesthesia is attained by 2% procaine hydrochloride solution with epinephrine hydrochloride.

The posterior incision as planned on the model is tattooed by a hypodermic needle with methylene blue or brilliant green along the proposed anthelix. The skin is reflected, the cartilage exposed, cut as predetermined, and the ellipse removed (Fig. *c*). To eliminate rebound elasticity the cartilage is trimmed to the edge above and below.

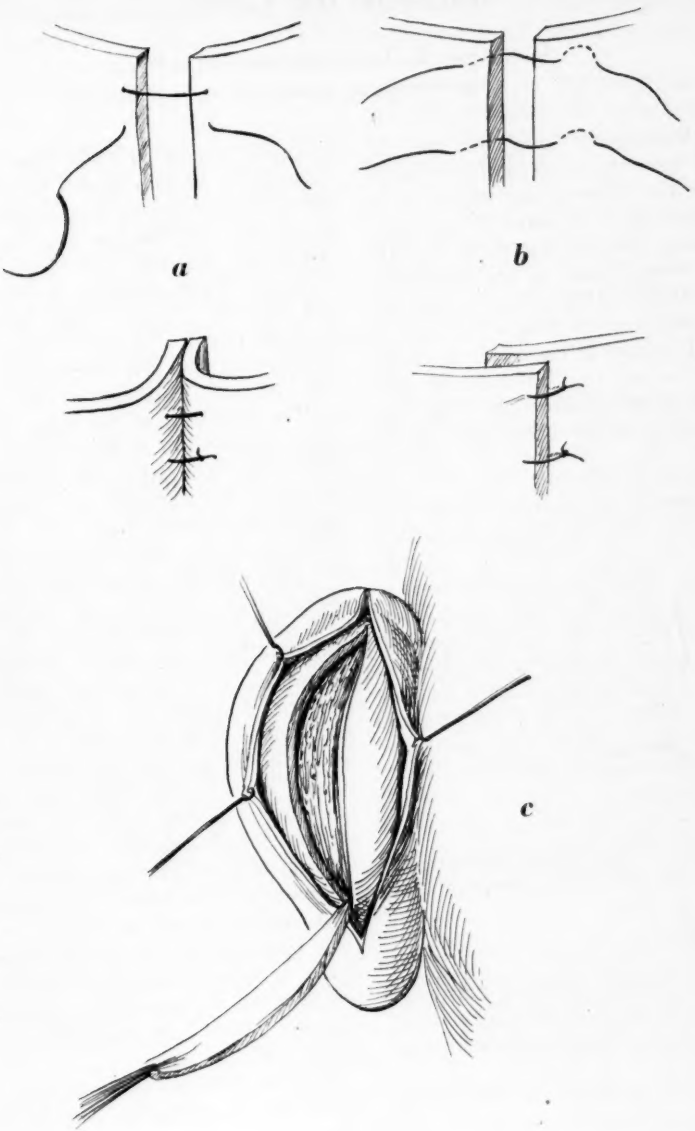
The cartilage is fixed in position with three or four fine silk or linen sutures. Superfluous folds of posterior auricular skin are smoothed by removing an ellipse about ½ in. wide.

The other ear is then operated upon. Before bandaging, symmetry of both ears is determined and bleeding must be controlled.

The posterior auricular fold, scapha, and concha are then coated with a varnish of 10% gum mastic, 10% styrax, and 80% chloroform, and packed with cotton. Gauze pads are applied and the head bandaged with wet crinoline for at least a week to ten days.

* Protruding ears. Arch. Otolaryng. 47:809-815, 1949.

SUTURING AND EXCISION OF AURAL CARTILAGE

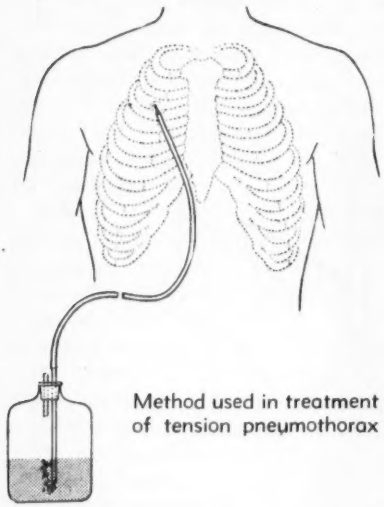


Injuries to the Chest

CLARENCE E. GARDNER, JR., M.D.*
Duke University, Durham, N.C.

HEMORRHAGE into the pleural cavity is rarely fatal after thoracic injury if the patient lives long enough to be taken to a doctor. Infection, although a possible troublesome complication, is not an immediate danger. Death from asphyxiation, however, is always imminent, warns Clarence E. Gardner, Jr., M.D.

Respiration can be seriously disturbed by contusion of the lung, loss of stability of the chest wall, pneumothorax, and hemothorax. Each may occur alone or in combination with either penetrating or nonpenetrating wounds.



Method used in treatment of tension pneumothorax

The only evidence of slight lung contusion may be a little chest pain with bloody sputum. Reflex bronchial secretion secondary to trauma, anoxia, or tracheal obstruction may be excessive and interfere with respiratory exchange. If the contusion is bilateral and extensive, alveoli and bronchi fill with blood and tissue fluid. Accumulations may not be expelled because of pain, instability of the chest wall, or inhibition of the cough reflex from oversedation or head injury. In such cases aspiration of secretions through a bronchoscope or a tracheal catheter may be necessary.

When several ribs are fractured in two places or the sternal plate is separated from the ribs, the detached parts move in opposition to the rib cage with each respiration. Breathing is painful, and the patient becomes cyanotic, dyspneic, and apprehensive and, unless promptly relieved by adhesive strapping, may die. When the sternal plate is detached wire may have to be placed under the costal cartilages and attached to overhead traction with weights and pulleys.

Pneumothorax, unless accompanied by a sucking wound or tension, is of little consequence. Air in the pleural cavity is usually absorbed within a few days but if respiration is affected, may be removed by aspiration with needle and syringe.

Tension pneumothorax is a grave condition. A valve-like tear in the

*Chest injuries. North Carolina M. J. 10:193-198, 1949.

pleura over the lung traps air which is pumped into the pleural cavity with each breath. The punctured lung collapses and the unaffected lung is compressed by displacement of the mediastinum.

The patient is cyanotic and dyspneic. The chest is hyperresonant and the trachea and heart are deviated from the affected side. Unless the air is released promptly, death may ensue. Pressure is released through a venipuncture needle thrust into the second interspace anteriorly and connected to an underwater seal (see illustration). If escape of air into the pleural cavity does not stop within several days, open thoracotomy may be necessary to remove a rib fragment or to close a lacerated bronchus.

When a tear in the parietal pleura exists concomitantly with tension pneumothorax, air pumped into the pleural cavity is forced into the tissue planes of the thorax. In this case, with each breath, the patient pumps himself up like a balloon, the air going from the top of his head to his toes. Insertion of a needle into one of the interspaces anteriorly, attached to an underwater seal, stops the progressive seepage of air into tissues. Residual air is absorbed in a few days.

Hemothorax is best managed by early and repeated aspirations. From 500 to 1,000 cc. of blood can usually be removed at each thoracentesis. Tightness in the chest is an indication to stop aspiration.

Bleeding from the lung ceases as the lung collapses, but operation may be necessary to control chest wall hemorrhage. Blood pressure restored by transfusion may drop again because of bleeding from an intercostal or internal mammary artery. When blood accumulates rapidly in the pleural cavity despite repeated aspiration, the suspected area must be explored, bleeding vessels tied, and the blood and clot evacuated.

Massive clotted hemothorax or fibrothorax, with or without infection, requires decortification. The entire clot is removed and the thick pleural scar dissected from the entire lung, mediastinum, chest wall, and diaphragm.

Penetrating wounds add the hazards of an open, sucking pneumothorax or a retained foreign body to the above conditions. If the wound is sucking, if tissues of the chest wall are contused, or if ribs are splintered, débridement with closure of the pleural cavity is necessary. Missiles larger than 1 cm. in diameter or fragments of rib within the pleural cavity, lung, or mediastinum should be removed to prevent infection or hemorrhage.

EXTERNAL OTITIS and chronic otitis media may be cured in a few days by sulfamylon, a para-aminoethyl benzene sulfonamide. Three times daily a 1% solution is instilled into the ear, allowed to remain five minutes, then blotted up with cotton. J. W. McLaurin, M.D., of Louisiana State University, Baton Rouge, continues treatment three or four days to a week and occasionally up to two weeks. The drug was effective in all of 141 cases.

Laryngoscope 58:1201-1205, 1948.

Prophylaxis of Ovarian Cancer

HAROLD SPEERT, M.D.*
Columbia University, New York City

REDUCTION of mortality from ovarian cancer is a serious problem; evey year several thousand women succumb to the disease. Because symptoms rarely appear until the tumor is well advanced and therapy ineffective, attempts at public education are practically useless. Theoretically all women should have frequent pelvic examinations, but few are likely to do so.

A more practical approach to the problem, suggests Harold Speert, M.D., is bilateral ovariectomy incidental to pelvic laparotomy in women over forty. The procedure is already accepted for hysterectomy after the menopause, and most women would willingly agree to having both glands removed if the hazards of possible cancer were explained beforehand.

A woman given anesthesia for any reason, especially during or after middle age, should have a thorough pelvic examination while unconscious. Ovarian regions must be palpated deeply and accurately with both hands.

A palpable adnexal mass noted after the menopause should be inspected by exploratory laparotomy. All enlarged ovaries observed in women over fifty should be excised, since 70% of such overgrowths are malignant.

In women with surgical lesions of the breast, pelvic involvement should be sought.

Unstable or frankly neurotic patients sometimes object to an abrupt or slightly premature menopause. But in the majority of cases management of induced climacteric requires only an understanding physician and a little sedation. If endocrine therapy is needed, oral medication is easy, effective, and economical.

The last 260 cases of ovarian carcinoma observed at the Sloane Hospital for Women were reviewed from the standpoint of possible prevention. Most of the neoplasms were adenocarcinoma, the others included teratoma, dysgerminoma, fibrosarcoma, and gynandroblastoma.

Pelvic, abdominal, or breast operations had been done in at least 26% of cases, and in some more than once. Over half were performed at or after the age of forty and 20% after fifty. Ovarian tumors may have been present at the time of operation, since in many cases the neoplasm was discovered one or two years later and occasionally within a few months.

* Prophylaxis of ovarian cancer. Ann. Surg. 129:468-475. 1949.

Conservatism had obviously been too great. Hysterectomy without bilateral oophorectomy was repeatedly done between the ages of forty-three and forty-nine; a single cystic ovary was removed at fifty, curettage and colporrhaphy done at sixty-four. Frequently pelvic examinations were not recorded or internal genitalia not described.

A few pelvic masses were misinterpreted, as when a hard, fixed, nodular structure was thought to be a myomatous uterus.

In 3.5% of cases, intrauterine radium or roentgen rays had been applied. However, no relation was demonstrated between irradiation and subsequent development of tumor. Only 2 instances of ovarian carcinoma have been discovered among 958 cases of radiotherapeutic menopause during observation periods of almost seven years. However, the latent period may be twenty years.

According to Vital Statistics of the United States, the chance that a woman of forty will die of ovarian cancer is greater than 1%. Mortality among white women beyond the first four decades was 17.02 per 100,000 in 1945.

Replacement of Iron Lost by Menstruation

RUTH FRENCHMAN, M.S., AND FRANCES A. JOHNSTON, Ph.D.*

MANY women lose enough blood during menstruation to require daily replacement of 0.08 to 1.21 mg. of iron. Since only 11 to 12.5% of the iron ingested is retained, menstruating women should have a daily intake of 10 to 11 mg. Those with excessive blood loss require more.

Supposedly standard meals may offer only 8 mg. In a sample menu prepared by Ruth Frenchman, M.S., and Frances A. Johnston, Ph.D., of New York State College of Home Economics and of Cornell University, Ithaca, N.Y., the extra amount is provided by spinach and by molasses in gingerbread. Iron may be found in such foods as liver, oysters, dried apricots, and prunes or by unusually large portions of meat and eggs.

	Serving Weight	*Iron*
BREAKFAST	*gm.*	*mg.*
Grapefruit sections	100	0.30
Grape-Nuts Flakes	15	0.65
Enriched bread	25	0.45
Coffee		0.00
LUNCH		
Cheese soufflé	110	1.50
Sliced tomato	50	0.30
Sliced cucumber	10	0.03
Gingerbread	50	1.47
Whipped cream	30	0.01
Milk	250	0.08
Enriched bread	25	0.45
DINNER		
Pork roast	60	2.00
Mashed potatoes	100	0.60
Buttered spinach	50	1.50
Celery	20	0.10
Fruit cup	100	0.43
Milk	250	0.08
Enriched bread	25	0.45
Total		10.40

* The relation of menstrual losses to iron requirement. J. Am. Dietet. A. 25:217-220, 1949.

when Milk becomes a dietary dilemma

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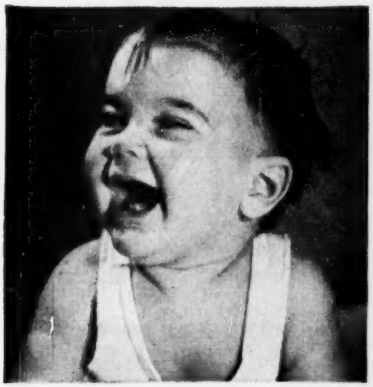

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When Milk becomes
"Forbidden Food"

Obliterative Suture for Hemorrhoids

HARRY J. FOURNIER, M.D.*
University of Illinois, Chicago

A CONTINUOUS suture eradicates small and medium sized internal hemorrhoids, especially the flat variety, and fixes the dilated veins to the rectal wall with dense connective tissue.

The obliterative technic is especially suitable for piles which cannot easily be clamped, excised, and ligated because of collapse when the rectum is dilated with retractors.

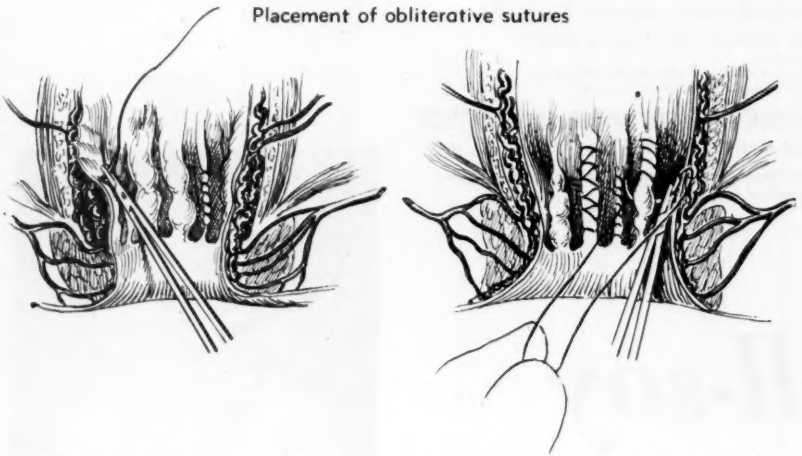
Harry J. Fournier, M.D., also recommends the method for internal hemorrhoids that lie between excised and ligated masses, where removal of additional rectal mucosa may cause undue trauma and hemorrhage.

With an atraumatic curved needle, threaded with 00 chromic catgut, the upper part of the hemorrhoidal mass is sutured to embrace slightly the muscular coat of the rectum. The first suture is used for anchorage and the needle is passed from side to side with from 3 to 4 mm. between the sutures. When the thread is tightened, the entire mass should be obliterated and fixed to the rectal wall (see illustrations).

Either the suture may end with a knot at the lower point of the mass or, if more secure obliteration is desired, the continuous suture may ascend in similar fashion to the starting point.

Lack of fascial support of the veins and looseness of the submucous connective tissue in the anorectal region

Placement of obliterative sutures



* Certain anatomic factors related to the pathogenesis of hemorrhoids. Ann. Surg. 129:156-160, 1949.

are the significant anatomic factors justifying the use of an obliterative suture for small and medium sized hemorrhoids.

This obliterative technic simplifies performance of a complete hemorrhoidectomy when other methods such as clamp excision suture and clamp cautery are used for large hemorrhoidal masses.

Significance of Linear Atelectasis

JEROME L. MARKS, M.D., AND ALVIN NATHAN, M.D.*

INTRA-ABDOMINAL disease is responsible for the majority of cases of linear pulmonary atelectasis and should be suspected whenever the roentgenographic sign is observed.

Causation of linear atelectasis from an abdominal condition is explained by Jerome L. Marks, M.D., and Alvin Nathan, M.D., of Marquette University and Milwaukee County Hospital, as follows:

Inflammation or elevation of the diaphragm produces shallow breathing and favors abnormal collection of bronchial secretions with consequent plugging of the peripheral bronchi or bronchioles. The usually elastic alveoli immediately above and below become emphysematous, permitting collapse in a horizontal direction. Vertical collapse is prevented by the relative fixation of the mediastinum medially and the negative intrapleural pressure peripherally.

The resultant plate-like atelectatic areas cover more than one plane of the lung. Roentgenograms show single or multiple striations rather than a solitary area of homogeneous density.

The striations may vary from thread-like lines to bands 0.05 cm. thick and frequently extend from the cardiac border in a horizontal or oblique direction. When oblique, the radiation is perpendicular to the interstitial markings of the lower lung fields.

Linear atelectasis usually occurs in the lower third of the lung fields, either unilaterally or bilaterally, just above the diaphragm, which is generally elevated and limited in motion.

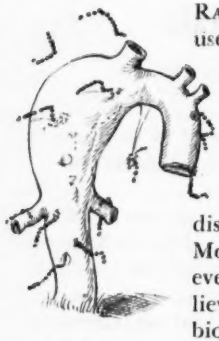
Linear atelectasis must be differentiated roentgenographically from interlobar pleuritis, which corresponds to location of fissures; from healed pulmonary infarcts, which are single, short, and take any direction; and from the fibrosis of old infections.

Among 7,064 consecutive chest roentgenograms of hospital patients, 29 cases of linear atelectasis were found. For 3 of these no primary source of the disease could be detected. In 22 patients the lesion was associated with intra-abdominal disease; the other 4 had intrathoracic conditions.

* The linear atelectatic sign in intra-abdominal lesions. Radiology 52:363-366, 1949.

Penicillin for Cardiovascular Syphilis

JOSEPH EARLE MOORE, M.D.*
Johns Hopkins University and U.S. Public Health Service



RATIONALE for the use of penicillin in treating cardiovascular syphilis is based on the drug's proven value in other types of the disease. Joseph Earle Moore, M.D., finds every reason to believe that the antibiotic will also heal syphilitic lesions of the aorta.

If administered early, several drugs will prevent cardiovascular involvement, which is 5 times more frequent among untreated subjects than among those given adequate metal chemotherapy.

Even therapy that is begun in the late phase of syphilis may forestall complications. Millions of persons have been treated for syphilis in the past twelve years, and the campaign is sure to be reflected in a great decline of cardiac and aortic injury during the next quarter century.

The best hope lies in recognizing the local involvement before saccular aneurysm or valvular insufficiency develops. The chances are that all poorly treated patients with noncongenital infection lasting ten or more years have microscopic lesions of the aortic wall.

The condition may be revealed by relatively minor symptoms, a few physical signs, and subtle radiologic changes, including:

► Aortic dilatation, increased density, and loss of elasticity can be detected by fluoroscopic examination, obliquely made films, or roentgenkymography. Unless the aorta is extremely distorted, routine posteroanterior teleroentgenograms and Vaquez-Bordet aortic measurements are useless.

► Heart failure or low cardiac reserve may be noted with no obvious hypertensive or valvular disease to account for the disturbance. Syphilitic heart failure is either congestive or anginal, and depleted reserve is ordinarily first shown by dyspnea or exertion.

► Localized substernal pain may be present. The sensation is dull, aching, relatively inconstant, not influenced by exertion, and not referred down the arms.

► The second aortic sound is accentuated and has a musical tone variously described as tympanitic, bell-like, or tambour.

Electrocardiographic changes are not specific for aortic infection but the tracing indicates probable involvement of one or both coronary ostia with reasonable certainty.

Even after aortic insufficiency and aneurysm develop, symptoms may be absent for long periods, and the pros-

* Cardiovascular syphilis. Am. J. Syph., Gonor. & Ven. Dis. 33:43-55, 1949.

pects of survival are better than generally realized, especially with treatment. Prolonged courses of arsenic, bismuth, and mercury approximately double the remaining years. Untreated persons with aneurysm live about forty-one months after onset of symptoms or recognition of the lesion, treated patients about seventy-four months. The outlook for aortic regurgitation is forty-five months of survival without and seventy-five months with therapy.

The dangers of reaction to penicillin have been much exaggerated. Many thousands of individuals with syphilitic aortitis must have received the drug and rumors of sudden death from the Herxheimer reaction are heard continuously. Yet only 4 case reports have been published as evidence, all unconvincing.

The Herxheimer reaction does indeed occur with all types of syphilis after doses of penicillin and arsenic, less often with bismuth and mercury therapy.

Effects are probably most frequent and severe with penicillin therapy and during the early stage of disease. Chills, fever, and malaise may begin six to twelve hours after the first dose and continue six to twenty-four hours. The local response consists of increased edema and cellular infiltration.

Moreover, unlike arsenic, penicillin response is unrelated to dosage and not prevented or ameliorated by initial small amounts. But when the drug was given in small or large amounts to 30 subjects, only 5 had febrile Herxheimer reactions; none showed cardiovascular symptoms not previously present, higher leukocyte count or sedimentation rate, or changes in electrocardiograms.

With aortic regurgitation, saccular aneurysm, or obvious or masked coronary or myocardial disease, penicillin might justifiably be withheld, at least until after preparatory treatment with heavy metal.

Nevertheless, the antibiotic should be used on an investigative basis for cardiovascular syphilis to outline the risks and benefits of a potentially valuable form of therapy.

AN INDWELLING URETERAL CATHETER which will remain in the kidney pelvis until removed by the physician employs the principle of the Foley bag catheter. George R. Livermore, M.D., of Memphis places the bag about 35 cm. from the end of the catheter (see illustration) instead of near the tip. The bag, therefore, rests

against the internal meatus when the catheter tip is in the kidney pelvis. All cases may be satisfactorily taken care of if three catheters, with the bag, respectively, 30, 32, and 35 cm. from the tip are available.

J. Urol. 61:753, 1949.

Test for Chronic Simple Glaucoma

SYLVAN BLOOMFIELD, M.D.*
Mount Sinai Hospital, New York City

BORDERLINE glaucoma can be revealed in one minute by a clear-cut demonstration of labile intraocular pressure. Sylvan Bloomfield, M.D., simply applies the cold pressor test during jugular compression.

By this means transient intraocular hyperemia is safely produced. Lability of tension is measured quantitatively and any defect in pressure regulation demonstrated.

The method is convenient for office or hospital practice and far more accurate in showing chronic uncomplicated glaucoma than other provocative technics. Equipment consists of a Schiötz tonometer, a sphygmomanometer, and ice water in a basin.

Eyes should not be under the influence of miotics. Water is thoroughly chilled by ice for fifteen minutes before the test. The blood pressure cuff is placed about the neck with the bladder in front, so that both jugular veins will be compressed simultaneously.

The tension of each eye is measured. The subject's open hand is then inserted in ice water up to the wrist, and at the same time the rubber cuff about the neck is inflated. Pressure should be kept above 50 mm. of mercury and preferably just below 60 mm. At this level neither arterial circulation nor breathing is disturbed although the face turns red.

In exactly one minute ocular tension is again recorded, the hand is withdrawn, and the blood pressure cuff removed. If the tonometer value has risen more than 9 mm., intraocular pressure is abnormally labile and chronic simple glaucoma is probably present. When the second reading is over 30 mm., diagnosis is more certain, whether or not the actual gain exceeds 9 mm.

On repeated tests glaucomatous eyes nearly always show exaggerated tension though not necessarily of the same degree at all times. Pressure returns to the original level in two or three minutes.

Elderly and hypertensive persons go through the procedure without undue discomfort or serious complaint. In over 300 cases not a single complication occurred.

Accuracy of the method has been observed in patients with healthy and glaucomatous eyes.

The lability test was positive in 91% of unoperated eyes with proved chronic simple glaucoma, the water-drinking method in 82%, diurnal tension curve in 30%, dark room technic in 17%, and caffeine test in 6%. Mydriasis produced by paredrine gave negative results throughout.

Eyes subject to recurrent acute congestive glaucoma do not react to the test in quiescent periods.

* The lability test: a new procedure for the diagnosis of chronic simple glaucoma. New York State J. Med. 49:659-662, 1949.

Medical Forum

Discussion of articles published in MODERN MEDICINE *is always welcome. Address all communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Quinidine in Auricular Fibrillation*

TO THE EDITORS: Dr. Howard B. Burchell's most excellent résumé of our present knowledge of the status of quinidine therapy of auricular fibrillation serves to spotlight our lack of progress in the treatment of this crippling cardiac condition. Since auricular fibrillation is caused by a variety of factors and a complete diagnostic study is obligatory before the administration of quinidine, I feel the general practitioner is not too well equipped to discriminate in the choice of patients for quinidine therapy.

One also wonders how fair it is to ask a general practitioner to give a drug so powerful that he is certain of 1 death in every 100, a death which he himself may produce so that the other 99 may live longer and more comfortably. This knowledge even in the hands of cardiologists engenders a caution in quinidine therapy which probably prevents the use of sufficient dosage in many a case that would be benefited by it.

We are at the threshold of a new era. The recent developments of angiography, venous catheterization, the use of kymography, and even the taking of intracardiac electrocardiograms have a direct bearing on research in auricular fibrillation. With these tools we should be able to test many substances which we know have quinidine-like action in this condition so that progress in this field will be made comparable to that attained in other fields of medicine. The ease of producing fibrillation in the test animal should help make this possible.

MAURICE KATZMAN, M.D.

Denver

► TO THE EDITORS: In my opinion, the old so-called indications and counterindications for the use of quinidine should be completely disregarded, and its value should be assayed in the light of more recent clinical and physiologic experience.

Quinidine, I think, is indicated for all patients with auricular fibrillation, particularly when associated with cardiac failure, who do not do well on routine management employing digitalis, low-sodium diet, dehydration, and so forth. Experimental work has shown that a fibrillating heart can be improved about 25% in mechanical efficiency if it is converted to sinus rhythm. No other drug is capable of doing this but quinidine, which is effective in about 65 to 70% of such patients if properly administered.

It should be emphasized that quinidine is never to be used in relatively

*MODERN MEDICINE, May 15, 1949, p. 42.

large doses, particularly in association with organic heart disease, unless the patient is first digitalized and then maintained on the latter drug while quinidine is being given.

Quinidine should not be employed in the patient with auricular fibrillation who, when adequately slowed by the proper use of digitalis, can be kept in a state of good compensation and has few or no symptoms. I repeat, however, that when the above therapy is ineffective, we are justified in using the drug, which, although attended with some danger, occasionally gives brilliant results.

JOE C. EHRLICH, M.D.

Phoenix

► TO THE EDITORS: In my opinion, the principal indication for quinidine in auricular fibrillation is to be found in the paroxysmal form, either as treatment or as prophylaxis. Results in established auricular fibrillation have in my experience been disappointing.

E. COWLES ANDRUS, M.D.

Baltimore

► TO THE EDITORS: Dr. Howard B. Burchell has covered the use of quinidine quite satisfactorily in his article on its use in auricular fibrillation and there is very little to add to what he has stated.

One might debate his statement that sudden death occurs as often as once in 30 severe cases. As I recall, Dr. White wrote several years ago that emboli were just as common in patients treated with digitalis as in those treated with quinidine, and this has been our experience. Severe reactions of circulatory collapse and asystole in our experience have been essentially uncommon and occur only objectively in patients receiving the drug intravenously.

It is our impression that the drug should be given throughout the twenty-four-hour cycle because it is rapidly excreted. Increase of dosage should be accomplished by decreasing the time interval between doses rather than increasing the amount of the drug.

CHAUNCEY C. MAHER, M.D.

Chicago

► TO THE EDITORS: Quinidine stops fibrillation by lengthening the refractory period of the auricular muscle and by slowing the speed of the cardiac impulse. If this slowing effect is more predominant, fibrillation persists.

Dr. Howard B. Burchell has covered this subject excellently. I should like to add to his list of contraindications to quinidine: sensitivity to the drug, and those cases of transient fibrillation lasting but a few hours and satisfactorily terminated by sedation.

Quinidine acts favorably in terminating attacks of fibrillation which complicate certain infectious diseases. Its action may be more efficacious if given to the digitalized patient. If quinidine fails to restore the heart to normal action, the patient should be maintained on digitalis, thereby slowing the ventricular rate, though not altering the fibrillation.

WILLIAM R. CROWE, M.D.

Atlanta

► TO THE EDITORS: The following comprises my list of indications for the use of quinidine in auricular fibrillation:

1] When fibrillation is comparatively fresh.

2] When there is very little or no cardiac enlargement.

3] Quinidine may be used as an adjunct in older cases or those of longer standing that do not convert after digitalis. Such cases frequently will convert and be maintained with quinidine.

4] When fibrillation persists after correction of a hyperthyroid state.

E. M. STEVENSON, M.D.
Bloomington, Ill.

Pyeloureteral Dilatation of Pregnancy*

TO THE EDITORS: The subject of pyeloureteral dilatation of pregnancy is of great interest because of the possibility of infection flaring up in the resultant urinary stasis. While I agree in part with the hormonal theory of its causation advanced by Drs. Ralph H. Jenkins and G. van Wagenen, several questions arise.

1] Why? There seems to be no physiologic need for such dilatation.

2] If the hormonal effect on the ureteral smooth muscle is incidental and accidental, why does not the smooth muscle of the blood vessels, intestine, and bladder also dilate?

3] Aside from primates and man, why do not other animals show a similar pyeloureteral dilatation?

I feel that the upright posture causes at least some obstruction at the brim of the true pelvis, not present in the quadrupedal posture. The postural pressure of the uterus is less with subsequent pregnancies because of the relaxation of the abdominal muscles; if the placental hormone were the sole cause, second and subsequent pregnancies should have similar dilatation.

Finally, I believe that the hormone sensitizes the smooth muscle, but that postural pressure is the direct cause of the stasis of urine, back pressure, and dilatation.

PAUL L. SINGER, M.D.
Phoenix

► TO THE EDITORS: My answer to the question of what causes the pyeloureteral dilatation of pregnancy was expressed in "The Influence of Hormones upon Varicose Veins in Pregnancy" *(West. J. Surg.* 51:199-200, 1943). To quote from my article:

It is believed that the progesterone-estrogen imbalance manifests itself in many ways during the nonpregnant as well as the pregnant state.

If in pregnancy there is present a relatively high level of progesterone, veins may dilate more than is physiologic; as well as the ureters, gallbladder, and the gastrointestinal tract.

A. M. MC CAUSLAND, M.D.
Los Angeles

The Insulins in Diabetes*

TO THE EDITORS: I would like to add a few words about the relative advantages of protamine insulin and globin insulin in diabetes as discussed by Franklin B. Peck, M.D.

Protamine insulin is appropriate in at least one-half of all diabetic patients who require insulin. As a class, these patients have a mild, easily controlled form of the disease, require small or moderate amounts of insulin

*MODERN MEDICINE, May 15, 1949, p. 63.

*MODERN MEDICINE, June 1, 1949, p. 64.

SUMMARY OF INDICATIONS

Protamine Insulin	*Globin Insulin or Protamine Insulin Mixtures*
Mild diabetes	Severe diabetes
Older diabetics	Young diabetics
Obese individuals	Thin individuals
Dosages under 40 units daily, with some exceptions	Dosages more than 40 units daily, with some exceptions
Fasting sugar levels high in proportion to postcibal glycosuria	Postcibal glycosuria heavy in relation to fasting glycemia
Stable forms of diabetes	Labile forms of diabetes
When globin insulin tends to cause afternoon insulin reactions	When protamine insulin tends to cause nocturnal insulin reactions
When no allergic tendencies exist	When allergic tendencies exist

for control of glycosuria, are not susceptible to insulin reactions, do not show glycosuria and hyperglycemia readily or in large amounts, seldom develop acidosis or have severe symptoms, and are not young or thin. The advantages of protamine insulin for this type of diabetes are that it need be injected only once daily, that it provides smooth, sustained, and gentle insulin effect which does not permit violent fluctuations in glycemia, and that it is painless on injection. Large dosages are required occasionally because of insulin insensitivity.

Globin insulin is most appropriate for use in severe diabetes where details of insulin timing are important. When glycosuria following meals tends to be heavy in spite of dosages of protamine insulin which control fasting, overnight sugar levels, or when protamine insulin tends to cause nocturnal hypoglycemia, globin insulin is ideal. Mixtures of about 2 parts regular or crystalline insulin thoroughly mixed with 1 part protamine insulin have about the same time-activity as globin insulin and are also most useful when the same pattern of glycosuria exists.

Globin insulin has the advantage of being marketed in solution rather than suspension, therefore not requiring uniform mixing before removing the dose from the ampule. It often causes some stinging on injection whereas protamine insulin and its mixtures are painless. On the other hand, it provokes allergic reactions less often than the protamine insulins. In severe diabetes it appears to be somewhat less predictable in action and to provide less profound overlapping of effect from day to day from multiple depots than the protamine insulins. Reactions are more likely during late afternoon than at night.

Extremely severe, labile, or "brittle" diabetics who are susceptible to sudden or violent shifts in sugar levels are best controlled by the use of globin insulin or a protamine insulin mixture which contains excesses of regular insulin, given in two injections daily, the larger amount before breakfast and the smaller at bedtime. This second dose provides a decidedly stabilizing effect at the end of the twenty-four-hour period when the activity of the large morning dose tends to be uncertain and inconstant.

ARTHUR R. COLWELL, M.D.
Chicago

The common occurrence of mixed infections in burns and chronic wounds suggests the use of an antibacterial agent with a wide antibacterial spectrum. Furacin, effective against the majority of wound bacteria in vivo, is receiving favorable and steadily increasing mention in the literature for such conditions.* Furacin® brand of nitrofurazone, is available as Furacin Soluble Dressing (N.N.R.) and as Furacin Solution (N.N.R.) containing 0.2 per cent Furacin. These preparations are indicated for topical application *in the prophylaxis or treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.*

EATON LABORATORIES, INC., NORWICH, N. Y.

*Bigler, J.: Chicago M. Soc. Bull. 50:269, 1947 • Coakley, W. A. et al.: Plast. & Reconstruct. Surg. 3:667 (Nov.) 1948 • Curtis, L.: Surg. Clin. N. A. 1466 (Dec.) 1947 • Downing, J. et al.: J. A. M. A. 133:299, 1947 • Johnson, H.: Arch. Dermat. & Syph. 57:348, 1948 • Mays, J.: J. M. A. Georgia 36:263, 1947 • McCollough, N.: Indust. Med. 16:128, 1947 • Mills, J. et al.: Plast. & Reconstruct. Surg. 3:245, 1948 • Ryan, T.: U. S. Nav. M. Bull. 47:991, 1947 • Shipley, E. et al.: Surg., Gynec. & Obst. 84:366, 1947 • Snyder, M. et al.: Mil. Surgeon 97:380, 1945.

Chlorophyll therapy in 127 cases of chronic osteomyelitis and ulcers

Excerpts from a clinical report (1) on an investigational study, published in the American Journal of Surgery, 77:162, 1949.

This report is one of an extensive series of carefully supervised studies on the wound healing effectiveness of Chloresium.

This synopsis is designed to give physicians a brief, convenient summary of the clinician's experience with Chloresium chlorophyll therapy. It quotes his reasons for choosing this method of treatment . . . his results in various types of cases. (1) *Original paper prepared by E. B. Carpenter, M. D.; Dept. Orthopedic Surg. Medical Coll. of Virginia Hosp., Richmond.*

"The action of chlorophyll as a therapeutic agent is essentially a stimulant to cellular metabolism . . .

"Because of disappointments and failures to obtain early healing in chronic granulomatous processes by the usual classical procedures, and with an increasing number of enthusiastic reports relative to chlorophyll preparations, in recent literature, the writer was stimulated to investigate these (Chloresium)* preparations clinically in a carefully selected and controlled series . . .

How the cases were selected

"The cases chosen for this investigation were carefully selected by a busy orthopedic service in a prominent teaching hospital. The cases selected were in each instance chosen by the writer and followed personally throughout their course of treatment and follow-up . . .

"The period covered in this clinical study was nine months: (See: "Follow-up observations" for final conclusions); 127 cases were selected and treated during this period . . .

Results in 59 cases of chronic suppurative osteomyelitis in which surgical intervention was held necessary

". . . Fifty-six healed per primum following the delayed closure and have remained healed without evidence of recurrence of infection or breakdown of the wound.

Results in 25 cases of subacute or chronic suppurative osteomyelitis secondary to compound fractures

". . . skin defects were covered and the wounds healed in twenty-three instances. The two other wounds broke down following skin grafting and required additional skin grafting or plastic closures . . .

"Following the start of chlorophyll dressings, the rapid disappearance of the foul odors associated with these cases was very marked in every instance and was most gratifying . . .

Results in 22 cases of chronic granulomatous wounds

"The group of chronic granulomatous lesions not associated with underlying bony infection consisted principally of decubitus ulcers. Nine such ulcers were on paraplegic patients and the results here were most gratifying. Early eradication of gross infection, early appearance of healthy granulation and progressive epithelization of these decubiti were marked in every instance.

* The water-soluble chlorophyll-derivative preparations used in this study were generously supplied by Rystan Co., Inc., Mt. Vernon, N. Y., and are marketed under the name "Chloresium" (Ointment, Solution [Plain]).

Results in 6 cases of chronic varicose ulcers

". . . diminution in the size of the ulcer occurred in every instance within two weeks and complete epithelization was obtained in four instances . . . in each case selected very definite improvement occurred with chlorophyll ointment although previously the ulcers had been resistant to all types of treatment.

CONCLUSIONS

"In the treatment of chronic suppurative osteomyelitis, both of hematogenous origin and secondary to compound fractures, the efficacy of chlorophyll solution locally combined with adequate sequestrectomy, produced uniformly rapid eradication of infection, early wound healing and substantial evidence of clinical cures, not previously experienced in this type of infection when treated by the usual time-honored methods.

"Chlorophyll derivative preparations in the treatment of decubitus ulcers, demonstrated tissue-stimulating properties, with subsequent early epithelization not previously seen in these particularly slow and indolent types of ulcer.

"Chlorophyll ointment locally as an adjunct to treatment of varicose ulcers previously resistant to all forms of treatment, demonstrated remarkable therapeutic properties.

Follow-Up Observations after 18 Months

"The period of follow-up has not been less than 18 months for any case and on a number of cases two years of observation have been possible.

"In the group of patients with chronic suppurative osteomyelitis, of whom fifty-four originally healed following sequestrectomy and delayed primary closure, two have developed recurrence of infection requiring additional surgery . . . The remaining patients have been clinically asymptomatic with no evidence of recurrence of infection . . .

"The group of cases of osteomyelitis following compound fractures has been very interesting to observe. Of this original group of 24 patients, additional surgery has been necessary in 6 . . . Of the entire group of 18 patients who have not required additional surgery there has been no evidence of recurrence of infection...

No breakdown in indolent ulcers

"The group of indolent ulcers or decubiti, particularly on paraplegics, have remained healed without evidence of breakdown.

"The 6 cases of varicose ulcers have unfortunately not been followed as closely . . . Observation on three of the most resistant has been possible and to date the ulcers have remained healed without breakdown in two of these cases. The remaining case had a 2 cm. area of breakdown which responded rapidly to chlorophyll ointment with subsequent healing.

"All of wounds (in the 15 cases of chronic suppurative osteomyelitis of the small bones of the extremities) progressed to eventual healing without surgical intervention . . ."

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Infectious Mononucleosis*

TO THE EDITORS: Dr. Raphael Isaacs' informative article on chronic infectious mononucleosis has called attention to an aspect of this interesting disease which does not appear to be widely known.

Most cases seem to run the usual course and after a period of several weeks' convalescence the patient is again perfectly well. However, a small percentage of cases are followed by a somewhat prolonged period of mild debility, at times associated with rather pronounced sweating tendencies. This period of debility may last for several months, and some people seem to be subjected to recurring bouts.

Consequently, I have adopted the principle of telling patients that they may experience this phenomenon of debility for varying lengths of time. I believe the debility is more likely to occur if the patient is not initially given adequate bed rest. If at all possible, I prefer to keep the patient at rest until the differential count is normal or is well on the way to becoming so. The total period of bed rest varies greatly and depends entirely on the severity of the infection.

A diagnosis of chronic infectious mononucleosis must indeed be very difficult to make unless one has a clear-cut history of the original acute attack. The finding of an occasional abnormal lymphocyte in a patient who has symptoms of mental depression, nervousness, giddy spells, and anxiety with sweating is not to my mind sufficient to confirm any such diagnosis.

A positive heterophil agglutination test strengthens the diagnosis as does the presence of slight splenomegaly and lymphadenopathy. Caution, however, is necessary in drawing too many conclusions from positive heterophil agglutinations of 1:64 and lower. Should no history suggesting an acute attack of infectious mononucleosis be obtained, the conclusion that the patient has chronic infectious mononucleosis must be reached only after exhaustive studies, and with reservations; such nonspecific findings might be obtained in other chronic diseases.

Dr. Isaacs' use of oral adrenal cortical extract with apparent improvement is interesting. When dealing with such a vaguely described group of symptoms, appraisal of a new therapeutic measure must be made very cautiously, because with the passage of time I believe these cases eventually recover.

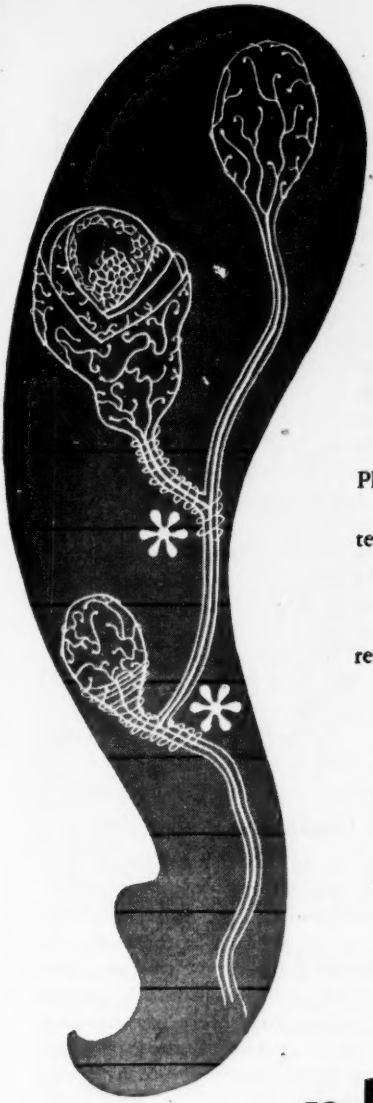
N. MCGILLIVRAY, M.D.

Toronto

► TO THE EDITORS: I should like to point out that the view expressed by Dr. Robert D. Barnard takes us back several decades in the study of infectious mononucleosis.

In discussing Dr. Raphael Isaacs' article on the disease, Dr. Barnard says that infectious mononucleosis is not a specific infection and not a nosologic entity. He further states that the hematologic findings are the same in a wide variety of conditions, such as allergy, infection, carcinomatosis, atypical pneumonia, toxic hepatitis, rheumatic fever, and influenza. He believes that the blood changes are due to a "reactive state seen in individuals of allergic or atopic constitutions whose lymphoid tissue is the sensitized

*MODERN MEDICINE, Nov. 1, 1948, p. 37.



* *In neuromuscular dysfunction*

Physotropin is an important adjunct in the treatment of neuromuscular dysfunction, as it tends to facilitate nerve impulse transmission. Physotropin employs the antagonism between Physostigmine and Atropine to remove the undesirable actions of the former without restricting its effect on the cranial nerves and skeletal muscles. Prescribe Physotropin. Your pharmacist can supply it.

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or shock organ. . . . such a lymphotic reaction is seen in some persons following the imposition of any stimulus classified among the cholinergic incitants, that is, infective, traumatic, radiative, allergic, or even psychogenic affection." He also denies that infectious mononucleosis is contagious and says that its "apparent epidemicity" is not "proof of its infective nature."

The disease is certainly an entity with definite clinical, hematologic, and serologic findings. Practically all those with much experience in this disease, as well as most investigators of viruses, are agreed that the specific agent responsible for the disease is a virus. Although sulfonamides and penicillin have not proved beneficial, I have seen a dramatic recovery with human convalescent serum and recently several very encouraging results with aureomycin. Advances in therapy will be forthcoming if it is realized that the disease is a specific infection, as most doctors now agree.

It is not correct to say that the hematologic findings in this disease are the same as in the conditions Dr. Barnard lists. Whereas it is true that the blood smears in infectious hepatitis and rubella frequently, and in lymphatic leukemia and Hodgkin's disease rarely, are very similar to those in infectious mononucleosis, any hematologist and almost any intern can distinguish between the smears in infectious mononucleosis and those in allergy, carcinomatosis, atypical pneumonia, rheumatic fever, influenza.

The statement that the blood changes are due to a "reactive state seen in individuals of allergic constitution" is not substantiated by clinical observation. In about 150 cases of this disease that I have seen, not over 10 to 15% were allergic patients; and the same is true in a series of hospitalized patients whose charts I reviewed. The theory that the blood findings are due to the individual's constitution rather than to the causative agent of the disease has not been held by authorities on this disease for many, many years.

Finally, one can no longer deny the contagious nature of infectious mononucleosis. I have seen as many as 5 persons in a household of 6 simultaneously ill with the disease; and there have been numerous epidemics in schools, nurses' residences, Army groups, and so forth. The occurrence of 687 cases in eighteen months at one Army post, reported by Wechsler, Rosenblum, and Sills (*Ann. Int. Med.* 25:113, 236, 1946), leaves no room for doubt concerning the contagious and epidemic nature of the disease.

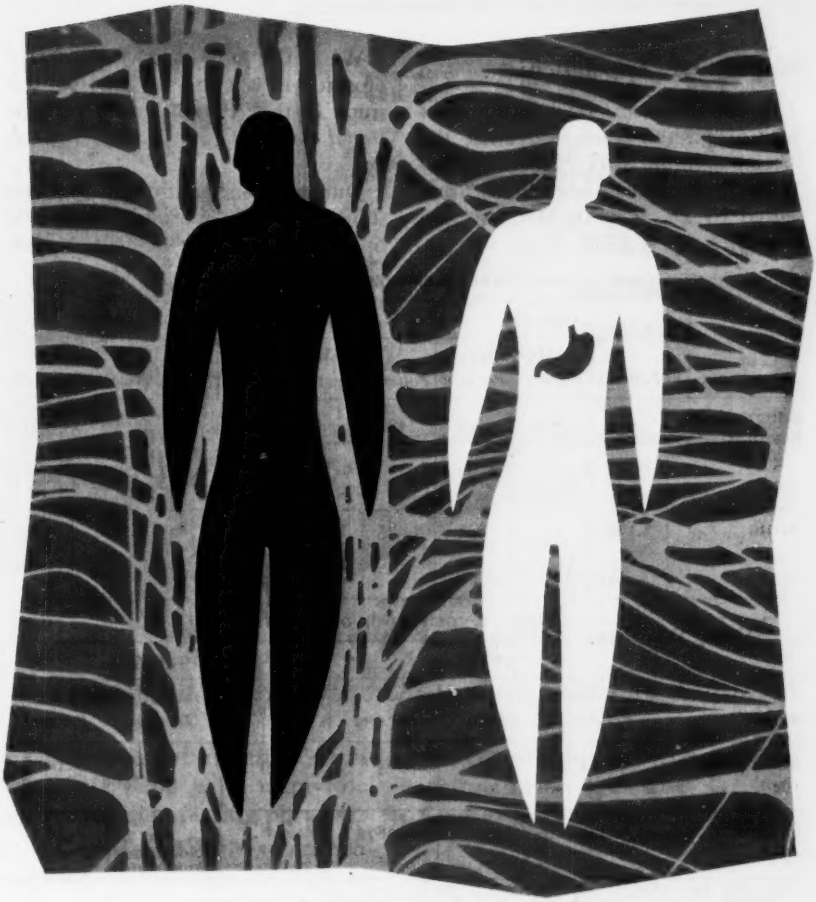
ROBERT E. KAUFMAN, M.D.
New York City

Mild Glaucoma*

TO THE EDITORS: I feel that the article by Drs. Adolph Posner and Abraham Schlossman is generally excellent, but I do not approve of the term *mild* glaucoma. I feel that any case, however mild in its symptoms, is capable of a sudden and severe exacerbation. Nor do I agree that miotic therapy may be unnecessary "if the symptoms are insignificant and the field shows no deterioration." Miosis, continuous and in proper dosage, may be a safeguard against further deterioration.

J. P. MCGRATH, M.D.
Kentville, N.S.

*MODERN MEDICINE, Sept. 1, 1948, p. 46.



The psychosomatic price

The tensions of modern living demand a price that is frequently gastrointestinal injury, occasionally peptic ulcer. The prevention and cure of peptic ulcer embrace the application of hygienic, psychiatric, dietary, and therapeutic techniques to this problem.

Logically, therapy should include the administration of materials which will tend to reduce the acidity of the gastric content without producing alkalosis or other undesirable effects. Coincidentally, a demulcent effect should be sought to coat the ulcerated surfaces and protect them from erosion. *Lederle* research has found that a casein, low in sodium, high in calcium, in appropriate form, when given by mouth will accomplish these ends and provide the patient with prompt symptomatic relief.

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Suppurative Appendicitis*

TO THE EDITORS: I read with a great deal of interest and enjoyment the special exhibit on "Treatment of Acute Suppurative Appendicitis," presented by Dr. Roy D. McClure and associates.

We at the Hollywood Presbyterian Hospital in Los Angeles reported this study in the *Journal of the International College of Surgeons* 11:154-169, 1948.

Our study and that of Dr. McClure show that the mortality from the operative treatment of acute appendicitis is steadily being lowered in our big hospitals. Patients suffering from acute, gangrenous, perforative appendicitis are those for whom the operation and the postoperative morbidity may still cause death and postoperative complications in the future.

TABLE 1. HOLLYWOOD PRESBYTERIAN HOSPITAL STATISTICS

Type of appendicitis	1933-47			1938-47			1943-47		
	Patients	Mortality		Patients	Mortality		Patients	Mortality	
		Deaths	Per cent		Deaths	Per cent		Deaths	Per cent
Gangrenous Perforative	759	70	9.22	384	29	7.5716	156	10 (None since Aug. 1946)	6.41
Acute	3,169	10	0.31	2,065	5	0.2420	784	0 (None since 1942)	0.00

TABLE 2. COMPARISON OF RESULTS

Author	1938-47			1943-47		
	Patients	Mortality		Patients	Mortality	
		Deaths	Per cent		Deaths	Per cent
McClure *et al.* 1949	1,411	9	0.64	559	0	0.00
Collins 1948	2,449	34	1.3872	940	10 (None since Aug. 1946)	1.061

I have compared the statistical results in this exhibit from patients treated at the Henry Ford Hospital with the results at the Hollywood Presbyterian Hospital over a comparable period of time. These results have been tabulated in chart form (Table 1) and a comparison drawn between our experience and that of Dr. McClure (Table 2). I thought that this chart might prove of interest to your readers.

Allow me to congratulate you upon the splendid presentation of this exhibit. I hope that similar exhibits will be presented in the future.

DONALD C. COLLINS, M.D.
Hollywood, Calif.

*MODERN MEDICINE, Apr. 15, 1949, p. 49.

Facts about General Electric Germicidal Tubes that every physician will want to know

THE General Electric Germicidal Tube is an ultraviolet source for disinfecting purposes.

G-E Germicidal Tubes can provide air disinfection of 95% or more kill of organisms within the direct zone of ultraviolet irradiation.

Germ concentration of air is diluted as normal circulation continually brings disinfected upper air down into the lower portion of a room.

Properly designed fixtures or devices provide protection from irritation to eyes and skin of persons by control of the energy.

The Council on Physical Medicine, American Medical Association, includes the General Electric Germicidal tube for hospital applications in its list of accepted devices. (J.A.M.A. 138:1157,1948)

Send for free booklet "Air Sanitation" with G-E Germicidal Tubes. Address General Electric, Dept. 166-MM, Nela Park, Cleveland 12, Ohio.

GENERAL ELECTRIC

Psychiatric Emergencies*

TO THE EDITORS: Dr. Max E. Johnson's article brings to the general practitioner some valuable points in the treatment of conditions met with in general practice. Every practitioner now realizes that practically all illness has a psychiatric aspect which may be mild or severe. This means that every practitioner must be his own psychiatrist for the conditions in his practice, although for the more complicated or difficult problems he may and probably should seek the assistance of a psychiatric specialist.

But even though the practitioner may be willing to assume entire care of the patient, including the psychiatric component, it is immediately obvious that many of the conditions discussed in this article cannot be cared for adequately at home. The physician should have just as easy access to hospital facilities for such conditions as are available for patients with fractures or for obstetrics and general surgery.

Consequently every general hospital should have specially equipped facilities for the diagnosis, temporary treatment, and care of such persons. The general hospital should accept this responsibility, setting aside 5 to 10% of its beds for this purpose. Only the difficult patients or those with prolonged illnesses would need to be transferred to the district mental hospital. Such a progressive step on the part of general hospitals would be a great aid to the physician in practice and would be of great value to sick people.

G. H. STEVENSON, M.D.

London, Ont.

*MODERN MEDICINE, Dec. 15, 1948, p. 45.

► TO THE EDITORS: The future mental and emotional health of the patient is not so greatly dependent on the treatment of the so-called psychiatric emergency as on the individual life pattern which is established in early life and governs the reaction.

J. G. WRIGHT, M.D.

Regina, Sask.

Indications for Tonsillectomy*

TO THE EDITORS: I am very reluctant to comment on Dr. E. T. Gaddy's article, in which he states that the majority of tonsils had been incompletely incised in the cases he observed. This one factor probably accounts for the observation that only 30% of the cases showed improvement.

His reasons for the incomplete removals are, I fear, too universal, too true, and really should not exist today. In addition to the need for proper anesthesia and adequate illumination during tonsillectomy, I would suggest adequate preoperative medication, less haste during the operation, the knowledge that each tonsil has an anterior and posterior pillar, which should be preserved, the inspection of the adenoid region after adenoidectomy, the assurance that all bleeding has completely ceased, and lowering of the head of the table during operation.

I agree readily with Dr. Gaddy's indications for tonsillectomy except that I would add deafness after an upper respiratory infection as an indication and would put a question mark after early glomerulonephritis.

D. B. LEITCH, M.D.

Alberta

*MODERN MEDICINE, Dec. 1, 1948, p. 49.

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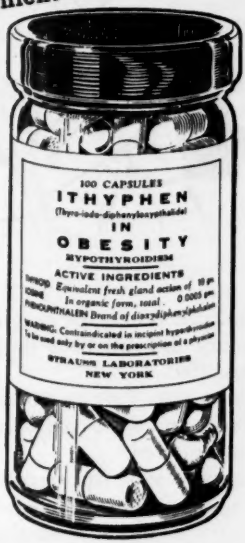

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Diagnostix

Here are diagnostic challenges presented as they confront the consultant from the first clue to the pathologic report. Diagnosis from the Clue requires unusual acumen and luck; from Part II, perspicacity; from Part III, discernment.

Case MM-146

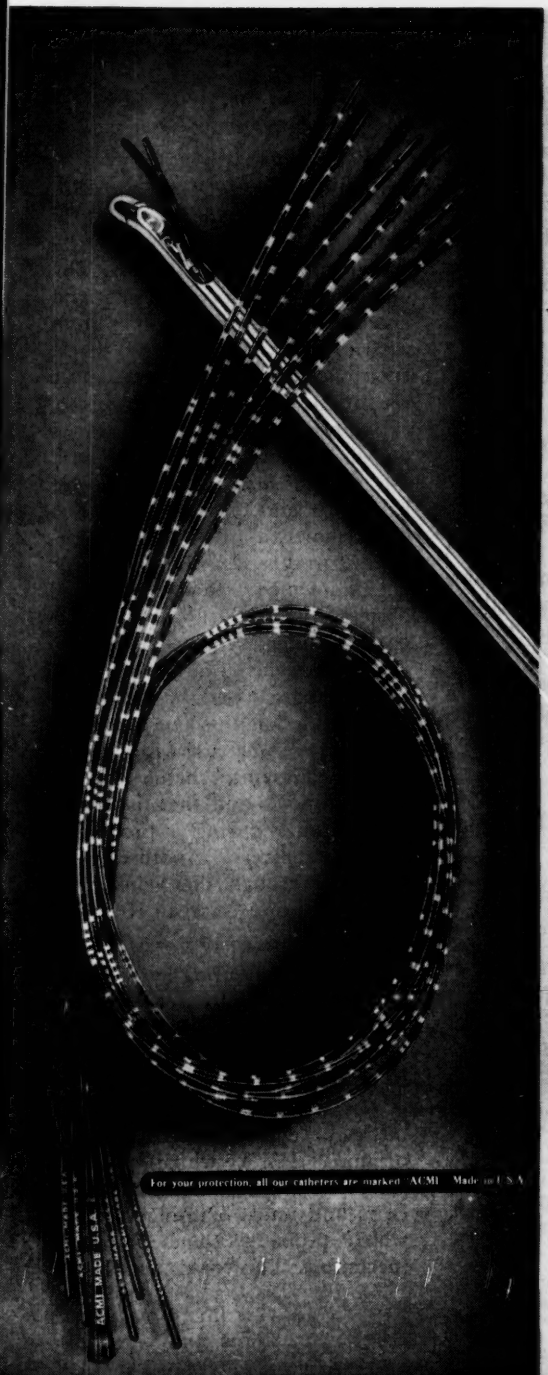
THE CLUE

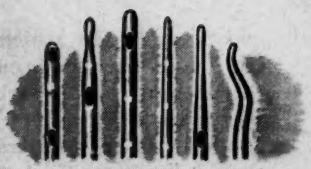
ATTENDING M.D: *(Walking down the hall outside the delivery room)* The obstetrician has asked you to see a patient who has suddenly gone into shock during closing of the uterine incision of a cesarean section. She is thirty-one years old and this is her first pregnancy. The infant has just been delivered and has died.

VISITING M.D: Tell me about the pregnancy and what complications were encountered.

ATTENDING M.D: Apparently the pregnancy had been uncomplicated until two days before admission to this hospital, when a brownish vaginal discharge appeared. This was noted by her physician, but no treatment was recommended. Suddenly, about ten hours ago, the patient expelled a considerable amount of blood through the vagina, but had no pain. A vaginal pack was inserted and she was rushed to the hospital by ambulance. A diagnosis of placenta previa was made. Because of breech presentation and an apparent pelvic dystocia, cesarean section was performed. The fetal heart was heard early in the course of delivery. That is all I know about the case.

VISITING M.D: *(Walking into the delivery room, having been gowned*





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and masked) The patient appears moribund. The blood coming from the operative site is dark and respiration is shallow.

ANESTHETIST: *(To Obstetrician)* We should begin artificial respiration at once. The airway is in, but I can't determine the blood pressure.

PART II

VISITING M.D: *(To Obstetrician)* Please tell me what the situation is.

OBSTETRICIAN: *(Inserting the transfusion needle)* As we began to close the uterine incision, the patient gasped for breath and the blood pressure dropped rapidly. She had not lost sufficient blood to account for the shock. The placenta had been removed completely and the patient's heart sounds had been normal. There had been no convulsions. Urinalysis and blood pressure were normal before surgery.

ANESTHETIST: I believe the patient has expired.

OBSTETRICIAN: *(Examining patient)* Yes, she is dead.

PART III

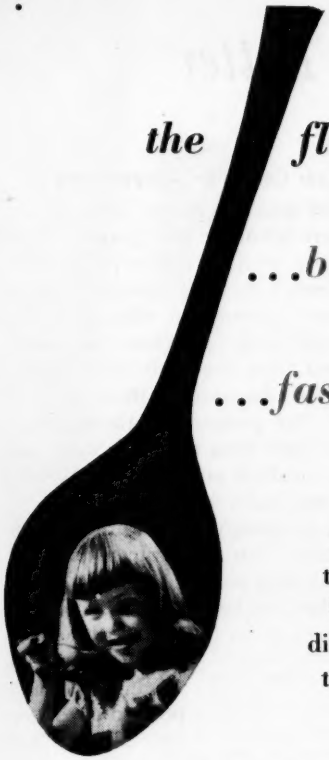
(Consultant, Visiting Doctor, and Obstetrician walk into the doctor's room.)

OBSTETRICIAN: This is a tragedy. The infant died without breathing, and now we have lost the mother from what looks like anaphylactic shock. It is difficult to know what the cause was. It happened so suddenly.

VISITING M.D: This may well be a death due to amniotic fluid and meconium embolus first described in 1941 by Steiner and Lushbaugh. Sudden death shortly after or during delivery due to this cause had previously been known by such descriptions as obstetric shock, acute pulmonary edema of pregnancy, and eclampsia without convulsions. The theory is that during a strong or tonic uterine contraction the amniotic fluid with the vernix caseosa or meconium exudes into the uterine venous sinusoids and then is carried to the lungs during a prolonged, difficult delivery. Another open pathway through the veins exists in the case of a cesarean section.

PART IV

PATHOLOGIST: *(Following autopsy four days later)* Death was due to amniotic fluid and meconium embolus to the lung as suggested by our consultant. The small arteries and arterioles of the lung contain fragments of epithelial cells and amorphous debris, which probably is vernix caseosa, and some small hairs and mucin-staining material, which probably comes from the meconium. The vessels are dilated.



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Washington Letter

No Doctor Draft This Year

Congress will wind up this session without devoting much attention to one of the government's pressing problems: how to get more physicians and dentists into the Armed Services. Time is too pressing to consider legislation as controversial as a physician-dentist draft.

Military officials, therefore, are seeking to reduce the work load and to induce reserve officers to spend a few days a month on active duty. The Army personnel already has been asked to request medical service for dependents only when absolutely necessary.

"Does this child have any reason to feel insecure?"

Volunteer Campaign Disappointing

A few months ago the Defense Department set out to get 15,000 medical men into uniform. The prospective volunteers were those educated at government expense but who didn't go on active duty and those who were deferred from the draft while finishing their education at their own expense. The pressure on these groups was to come from national, state, and county medical associations and from press and radio appeals.

The campaign bogged down at the very start. Not all professional associations were willing to help. A complete list was lacking of the men deferred while completing schooling. Then, too, a large portion of the 15,000 already had served or were serving the required two years.

As a result, about 500 physicians and dentists signed up or are likely to. That leaves a potential shortage of more than 3,000 by next December.

Step toward Medical Unification

For the first time, the three military medical services will have

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control gastric acidity without Alkaline assault ...

Resmicon T. M.

Peptic ulcer therapy, with Resmicon through scientific application of the physical properties of resin and mucin, places in the hands of the physician a new and remarkably efficient technic for control of gastric acidity.

The special anion-exchange polyamine resin contained in Resmicon *physically adsorbs excess acid*, subsequently releasing the captured chloride ions in the alkaline environment of the intestine. There is no violent chemical reaction with its resulting dyspepsia and the formation of astringent constipcting by-products. Rapid reduction of acidity to physiologic levels is smoothly produced and efficiently maintained without danger of toxicity, hyper-alkalinization, acid rebound, or chloride loss.

Resmicon is available in bottles of 84 tablets, each tablet containing 500 mg. anion-exchange polyamine resin and 170 mg. gastric mucin.

The mucin component of Resmicon provides a tenacious, protective coating, resistant to the diffusion of acid and pepsin alike . . . it produces a mechanical barrier against autodigestion.

Of great importance in view of the etiologic role of pepsin in the production of gastric ulcer is the fact that both resinous and mucinous components of Resmicon tend to inhibit the action of this enzyme.

In uncomplicated hyperacidity or in peptic ulcer Resmicon provides more efficient control than the customary alkaline antacids without their hazards.

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one director. In creating the office, Defense Secretary Louis Johnson said that the director would have the responsibility and authority to establish and control policies, standards, and programs. However, each department will retain its own entity.

The new director is expected to move toward unification by cautious stages, giving attention first to joint purchase of supplies then to joint training programs.

At the time he announced the new office, Johnson also gave the Air Force Medical Department autonomous status and ordered the Army and the Navy each to transfer 100 medical officers to it.

Health Insurance Sponsors Stress Two New Points

Hearings on President Truman's national health insurance program disclose two new strategic approaches by sponsors of the plan.

J. Donald Kingsley, acting federal security administrator, presented one of the arguments at the opening of the House hearings. He said that there was wide misunderstanding of the nature of the plan, that the Truman proposal is *not* socialized medicine, but that it is the only way to prevent socialized medicine.

Kingsley pointed out that hundreds of thousands more people each year become direct medical charges of the government. Among them he listed the dependents of employees of government overseas contractors, many mental and tubercular cases, veterans in and out of the hospitals, Army, Navy, and Air Force personnel, and the indigent. These cases, he emphasized, are state medicine—socialized medicine in the strictest sense. He added:

> It is evident that the acceleration of this development in recent years has been phenomenal. There is no reason to suppose that it can be halted by partial or makeshift expedient.

Other witnesses carried this argument further. They said the next step will be demands that dependents of all veterans receive full medical care. If this occurs, they said, a majority of the population will be getting its medicine completely free, directly from the government. To care for them, the argument went on, the government will have to hire a majority of the physicians and put them directly on the government's payroll. Then it would be too late for health insurance, and the private practice of medicine would be doomed.

Southern congressmen and senators are alert to another development in the health insurance dispute, centering around a small pamphlet, *How a National Health Program Would Serve the South*, published by the Committee on Research in Medical Economics. The pamphlet is being promoted, both in the hearings and out, by the Committee for the Nation's Health, formed to back the Truman plan. Politically the argument will be effective in inducing a group of southern lawmakers to reconsider their already expressed opposition to health insurance. The pamphlet makes the obvious and impressive point that most southern states would come out ahead financially under the Truman health plan while their health services were being improved.

The group publishing the pamphlet is described as "a non-profit cor-

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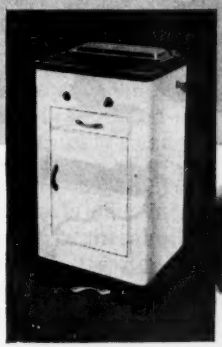

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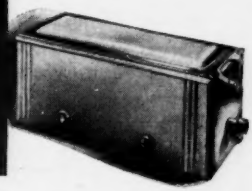

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poration which conducts studies of medical services with particular attention to their economic and social aspects," but it has close connections with the Committee for the Nation's Health.

AEC Row May Kill Science Foundation for This Year

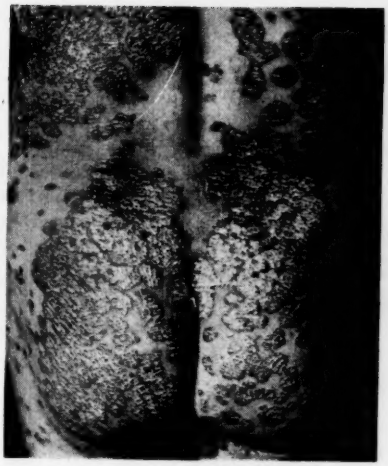
The violent argument over what part loyalty examinations should play in awarding fellowships now threatens to defeat the National Science Foundation act. The need for such a foundation has been beyond argument since the end of the war.

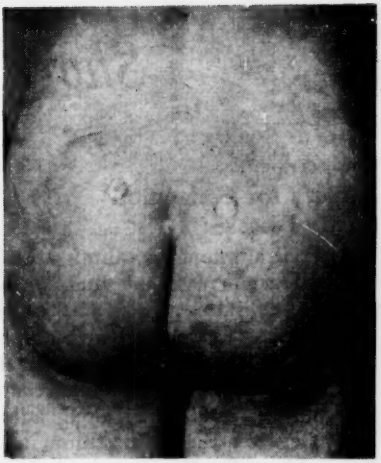
One bill was vetoed by President Truman because he considered it administratively unworkable. But since then most administrative details had been ironed out and, until the argument over loyalty investigations, there wasn't much in the way of passage. Its chances of getting through now aren't too good. Here are the curious details:

The argument over scholarships came into the open during the investigation of the Atomic Energy Commission. Chairman David Lilienthal told the joint committee that loyalty investigations should be confined to applicants for work in secret projects, otherwise. "Where are you going to stop?"

Mr. Lilienthal apparently didn't win the committee over to his way of thinking, because next day the commission itself began to back down. By this time, scholarships and fellowships in themselves had suddenly become a major issue. Where a few weeks ago the lawmakers were satisfied with the foundation's system for awarding grants, now they wanted to make sure no money would go to students with the wrong political views. All of which is going to take time.

"... You're from Boston, of course?"





Symptomatic Relief First

before confronting the vagaries of psoriasis

(Left)
Psoriasis of 15 years' duration

(Right)
Same case after 5 weeks with Mazon

• Facing the bewildering and erratic behavior of psoriasis, the clinician logically turns to localized treatment first before instituting more generalized therapy.

With Mazon, a compound of mercury salicylate, benzoic acid, sodium stearate, salicylic acid and tars, progress of the lesions is arrested and symptomatic relief is quickly accomplished.

As demonstrated for over 25 years, Mazon acts efficiently in psoriasis when systemic or metabolic involvement is not indicated. Its non-staining, non-greasy and generally agreeable properties promote patient acceptance.

MAZON

BELMONT LABORATORIES, Philadelphia, Pa.

Short Reports

CARDIOLOGY

Surgery for Congenital Heart Disease

Arterial anastomosis cannot always be used to increase the lung blood supply for children with cyanotic congenital heart disease. When pulmonary arteries are lacking or too small for anastomosis, new vascular channels may be established along adhesions between the mediastinum and lung. The adhesions are formed by stripping the parietal pleura from the upper part of the chest, then powdering the raw surface with asbestos dust, and reexpanding the lung. The operation may be done on both sides. Considerable revascularization occurs. As an alternative, omentum may be brought up from the abdomen and applied to the lung. Drs. N. R. Barrett and Raymond Daley of St. Thomas's Hospital, London, have used one or the other procedure for 6 children. Results were considered good for 2, and 3 showed considerable improvement.

Brit. M. J. 4607:699-702, 1949.

PHYSIOTHERAPY

Radar in Treatment of Arthritic Conditions

Microwave energy may provide a safe, convenient source of therapeutic heat for treatment of arthritis, bursitis, and muscle inflammation. Radiation by microwaves of the length and frequency used for radar during World War II increases the circulation through the irradiated area. Dr. Khalil G. Wakim and associates of the Mayo Clinic, Rochester, Minn., report that 70 patients have received a total of 670 microwave applications without untoward effect. The majority of patients had acute subdeltoid or subacromial bursitis or chronic periarthritis of the shoulder. In most instances both subjective and objective improve-

ment was fair to excellent. Pain was increased, however, in 4 cases. Microwave radiation may be contraindicated or at least should be used with caution over tissues with impaired circulation or high fluid content and over regions containing metallic implants or with hemorrhagic tendencies. Microwave apparatus for heating large areas of the body is not yet available.

J.A.M.A. 139:989-993, 1949.

ONCOLOGY

Iodoacetate Index in Detection of Cancer

Thermal coagulation of serum proteins, while not specific as a diagnostic instrument, is useful in early detection of cancer. When subjected to heat, plasma from patients with cancer tends to coagulate more rapidly than does plasma from healthy persons. The complex physicochemical change may be irreversibly inhibited, however, by iodoacetate, which is iodoacetic acid at *p*H 7.4. Iodoacetate apparently reacts with molecular linkages essential to clot formation. Thus the total availability of such linkages may be mathematically expressed as the iodoacetate index. Patients with cancer seldom have as high an iodoacetate index as healthy persons. With an index of 9 arbitrarily set as the minimum for normal serum, Dr. Charles Huggins and associates of the University of Chicago classified the sera of 300 individuals into three categories according to coagulative characteristics. All of 85 patients with active cancers had iodoactetate indexes of less than 9. However, 16 of 95 patients with nonmalignant diseases also had sera that came within the same low range. Sera of patients with pulmonary tuberculosis, for instance, resemble sera from cancerous patients in coagulative aspects and have a similar iodoacetate index. Sera of patients with benign tumors coagulate like those of healthy persons.

Cancer Research 9:177-182, 1949.

AWARDS

Penicillin Research Honored

High award in the field of pharmaceutical research, the Ebert Prize, has been presented to Dr. Robertson Pratt, associate professor of pharmacognosy in the University of California, San Francisco. The award was made by the American Pharmaceutical Association for work with chemicals that, in trace additions, will increase effectiveness of penicillin.

HONORS

Howard Ricketts Award

Medals of a new national medical award, established in honor of Dr. Howard Taylor Ricketts, have been presented to Dr. Ludvig Hektoen of the University of Chicago and Dr. Russell Wilder of the Mayo Clinic, Rochester, Minn. Dr. Ricketts was the first man to observe the organisms, named *Rickettsia* in his honor, that cause Rocky Mountain spotted fever and typhus fever.

GRANTS

Research at Pennsylvania

A new heart clinic building and a grant of $25,000 for cancer study have been donated to the University of Pennsylvania by the Penn Mutual Life Insurance Company of Philadelphia.

BLOOD REGENERATION

IN SECONDARY ANEMIA

• Non-utilization of iron prescribed for the anemic patient, and its consequent excretion fecally, produces gastrointestinal upset and often defeats the original purpose for which it was intended.

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WATER SOLUBLE **COPPERIN** NON-STAINING

CANCER

Acid Phosphatase Activity in Human Neoplasm

Cancers in man exhibit a uniform increase in nuclear acid phosphatase when compared with tissues of homologous origin, probably indicating a fundamental enzymatic disturbance in the carcinomatous tissue. In investigating the quantitative microchemical changes involved in the malignant transformation of human epithelial tissues, Drs. Henry M. Lemon and Charles L. Wisseman, Jr., of Boston University attempt to preserve cellular integrity as much as possible by avoiding protein denaturation during fixation and heating. Reproducible measurements thus obtained show that the activity of tissue phosphatase, a universal nuclear component of human tissue, is definitely related to rate of tissue growth and secretion.

Science 109:233-235, 1949.

"Two hamburgers, two coffees, and we're in a hurry."

EXPERIMENTAL MEDICINE

Hormones for Peptic Ulcer

Hormone therapy may retard development of peptic ulcer and promote healing of ulcers already formed. From observation of dogs with ulcers induced by the Mann-Williamson technic and treated with several glandular extracts, Dr. Harry C. Saltzstein and associates of Wayne University, Detroit, report that:

► Best results are obtained by daily injection of human pregnancy urine extract. Parenteral administration of extracts of normal male and female urine which does not contain anterior pituitary-like hormone is also beneficial, as is the follicle-stimulating hormone obtained from pregnant mare's serum.

► Oral administration of human pregnancy urine extract stimulates epithelization but does not prolong survival. The same result is obtained by injection of progesterone.

► A combination of posterior pituitary extract and luteinizing hormone does not prolong survival but does seem to enhance healing of craters.

► Administration of a foreign protein from defatted milk increases time of survival but does not exert a healing effect.

► Total gastrectomy is usually followed by nutritional disturbances that prove fatal.

► Some benefit may be obtained from oral enterogastrone and from parenteral use of either an extract obtained from urine of patients with inoperable carcinoma of the stomach or an extract prepared from beef heart muscle tissue.

Gastroenterology 12:122-132, 1949.

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Babies are our business... our only business!

How Is the British Doctor Getting Along?

(Continued from page 48)

matter how expansive. He can get a wide range of equipment and appliances—eyeglasses, trusses, hearing aids, crutches, artificial limbs, or a wheelchair. The doctor may call in a health service consultant when he desires. He can send his patients to the hospital for treatment or diagnosis, as either in- or out-patients.

The patient also gets dental care from a health service dentist—expectant mothers and children under five get priority—and eye care from an ophthalmologist or optometrist, as he chooses.

Almost all of this is entirely free at the time of service, although everyone pays in general taxation and payroll deductions. Mr. Patient, however, pays directly in some cases, for instance, to renew or repair spectacles or dentures. If he can afford it, he must also pay for domestic help made necessary by sickness and for extra food or blankets. If he desires more expensive appliances than the government's utility brands, he must buy them himself.

Frequently, in fact, the patient receives payment, for Britain's social security system includes maternity grants and allowances, disability pay upon sickness or injury, and a regular dollar-a-week family allowance for every child after the first.

Britain's health service GP's average 2,200 state patients, but distribution is spotty—too few patients for a good living in many rural areas and well-doctored suburbs; too many for good doctoring in most of the cities. The maximum permitted, except where doctors are especially scarce, is 4,000 state patients. That load, or near it, is all too common, say critics.

Lord Horder, former physician to the king and the leader of the anti-government Fellowship for Freedom in Medicine, charges: "The essence of good doctoring is diagnosis, which calls for time and a close-up with the patient, both now denied to thousands of practitioners. That a doctor cannot pay his way unless he has 4,000 possible patients on his list is as great a disservice to the public as to medicine."

Britain's GP's, long overburdened even under the old Lloyd George panels, now fear becoming, as one put it, "second-class sorting machines." General practice, warns the *Lancet* (sympathetic to the health service), "seems likely to deteriorate unless remedial action is taken."

Conditions in London, with a fifth of Britain's population, are most trying. Listen to some comments from Dr. J. S., GP with just under 3,500 state patients, perhaps 7 to 10 private patients a day (more than most; his office is in a business district) and two part-time appointments as factory medical officer. I interviewed many doctors, and found his comments typical:

"My day begins with two or three home visits. Then morning surgery [office hours] starts at 10. I'm lucky if it's over by a quarter to 1, and I only finish then because I've worked so fast and so carelessly.

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Moisture		6.0%
Crude fiber not over		2.0%
Phosphorus	0.51%	(145 mg. per oz.)
Iron	0.03%	(7.5 mg. per oz.)
Copper	0.001%	(0.3 mg. per oz.)
Calories per ounce		104

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"A half hour for lunch, then fourteen or twenty home visits, afternoon factory sessions, and emergency calls. Evening surgery starts at 6 P.M. I'm lucky to get home by 8 or half-past. Then I hope for a night without any calls.

"I see 75 or 80 patients a day now. The number's up at least 50%. It's not the best doctoring. I go through many examinations without asking the patient to remove his shirt. Only if a patient returns many times, with no relief, do I try any thorough clinical exam, and then I may have to send him to a hospital for the examination.

"I'm reasonably fast. But one doctor tells me he's a third again as speedy. I'm afraid he has less conscience. I try to satisfy at least the patient if not myself. In the highly populated East End, doctors regularly see more than 100 patients a day. Some never finish before midnight.

"One of my greatest worries today is that I'll have to send a patient to the hospital. They're sorely crowded. The situation was very poor even before. Now it's impossible, if you want the ordinary patient admitted.

"Oh, I still think socialized medicine is great for the people. I voted against it because the government wasn't offering doctors a square deal. When the people get the service they should get, all free, it will be wonderful. For instance, I can get a specialist consultation now without its costing a cent. For a revolution, I suppose, it's working well. But I'm tired."

How much has the load increased since July? A government survey showed that July to September 1948 as compared with July to September 1947 saw only a 4% increase in sick adults visiting doctors. This survey, however, included only those who said they had been ill, it left out "routine visits" for examinations, various certificates, prescription refills, immunization, and prenatal or postnatal care, and it did not indicate the heavy load among children.

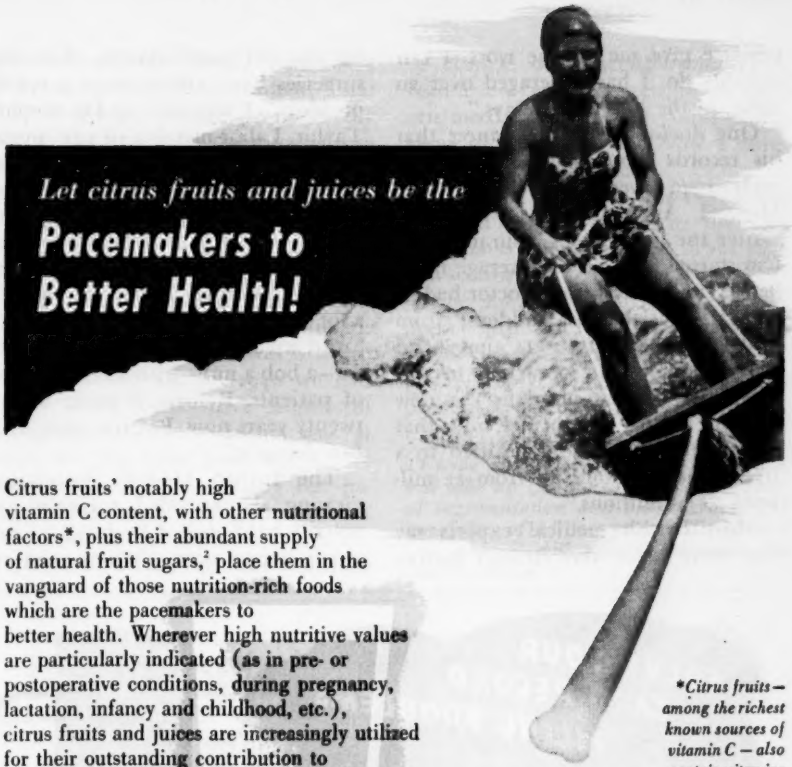
The well-informed *Lancet* last November estimated visits were up by a quarter to a half, depending on the area. This journal calls the service the "best yet," but also reports:

> Most practitioners regret that the price of more equal attention for all must be less attention for each. In the long view the only solution is to have more doctors, and in the short to conserve the doctor's time for his strictly professional work.
>
> At one pole the acutely ill patient, and at the other the patient with mild bronchitis, are likely to fare no differently than they have hitherto. Between these two extremes the difference threatens to be substantial.

The doctors I talked to confirmed this. Remarked Dr. Thomas England in a Cardiff slum: "I'm working twice as hard now—85 patients a day. As far as medicine, it just isn't good." Dr. E. J. B. Sewell in a little Welsh coal town told me: "I'll see close to 100 patients today, but I've had as many as 180 when things are really whipped up—say when an influenza epidemic is on. I don't walk anyplace any more. I run."

An associate in the same town said: "I have 5,200 on my list, and I ran it myself until last March. Then I got an assistant. It's still deadly—a slave's job, sometimes day and night."

Dr. D. M. O'Connor of Launceston, Cornwall, wrote the *British Medical Journal* this spring: "I might be classified as 'lazy'. . . . but I find that 2,250 names on my list in a partly rural



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Your patients will welcome your advice to consume liberal amounts daily of Florida citrus fruits and juices (either canned, fresh, frozen or concentrated) because of the well-known gustatory appeal, pleasing forms, ease and variety of serving, and refreshing, tart taste of these foods.

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references:

1. Bridges, M. A.: Dietetics for the Clinician, Lea & Febiger, Philadelphia, 4th ed., 1941.
2. McLester, J. S.: Nutrition and Diet, Saunders, Philadelphia, 4th ed., 1944.
3. Rose, M. S.: Rose's Foundation of Nutrition, Rev. by MacLeod and Taylor, Macmillan, New York, 4th ed., 1944.
4. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, New York, 7th ed., 1946.

practice give me all the work I can possibly do. I have averaged over 20 visits on the last six Sundays."

One doctor wrote the *Lancet* that his records show visits up 30% for early 1949 over 1948. The British Medical Association has reported: "After the [workmen's insurance] system started in 1911, the average number of times the average doctor had to see each patient rose suddenly from under twice a year to 3½ times, and that number has since risen to five times. Even more heavy is the new burden falling on doctors now that the number of persons entitled to a free service has shot up from 22 millions to 50 millions."

Most British medical experts say that there never were enough doctors for the old panel system. "Crowded surgeries have always been a terrific problem," I was told by Dr. Stephen Taylor, Labor member of parliament, Socialist Medical Association member, and parliamentary private secretary to Herbert Morrison, Labor party leader.

"We've always had a lot of the very worst doctors in Britain, along with a lot of the very best," Dr. Taylor said. "And we always had the shilling doctor—a bob a nob—with a steady stream of patients. Reform is going to take twenty years now. But it's going to be fun doing it."

The British Medical Association, viewing the crowded surgeries and equally hard-pushed hospitals, sounds a less happy note. "We warned the

government," said Dr. H. Guy Dain, chairman of the BMA council, "that there was not the man power in the medical profession or the nursing profession nor the hospital beds available to implement the service. Our warning was not heeded and now we are reaping the unfortunate consequences."

Dr. J. S., the London GP, fortyish and balding and fidgety, concluded:

"The war, remember, was a strain for over five years. In 1940 we had ninety some consecutive nights of bombing, and every doctor was at work. We had blitz, buzz bombs, the dreadful V2's. And treating the patients of doctors in service. It took something out of us.

"Now I haven't time for a lecture or clinical demonstration, let alone read a few books to keep up on modern medicine. Before, I could play a game of golf or tennis. Now I never have an afternoon free.

"I'm only forty-two, but I get home at night too exhausted to eat. Old patients say, 'Doctor, I've never seen you so worn.' "

The *Lancet*—unlike Dr. J. S.—remains optimistic. But it pleads for reforms and concedes that many will be possible only if impoverished Britain progresses toward economic recovery.

In the concluding article in the July 15 issue of* Modern Medicine *Mr. Cohn will take up* [1] *doctors' pay,* [2] *fears of regimentation and bureaucracy,* [3] *possibility of a "doctors' rebellion," and* [4] *what it will take to improve the health service.

Current Books & Pamphlets

This catalogue is compiled from all available sources, American and foreign, to insure a complete listing of the month's releases.

Medicine

DISEASES OF THE LIVER, GALLBLADDER AND BILE DUCTS *by* S. S. Lichtman. 2d ed. 1,135 pp., ill. Lea & Febiger, Philadelphia. $18

MEDIZINISCHE KLINIK *by* F. Hoff. 467 pp., ill. Georg Thieme, Stuttgart. 29.60 M.

THE STRUCTURE OF MEDICINE AND ITS PLACE AMONG THE SCIENCES *by* F. M. R. Walshe. 26 pp. E. & S. Livingstone, Edinburgh. 1*s.* 6*d.*

Gynecology & Obstetrics

SAFEGUARDING MOTHERHOOD *by* Sol T. DeLee. 135 pp., ill. J. B. Lippincott Co., Philadelphia. $2

FACTS ABOUT THE CHANGE OF LIFE *by* E. C. Hamblen. 100 pp., ill. Charles C Thomas, Springfield, Ill. $2.50

LEHRBUCH DER GEBURTSHILFE *by* H. Martius *et al.* 2 vols. 1,176 pp., ill. Georg Thieme, Stuttgart. 72 M.

ANAEMIA IN PREGNANCY IN CALCUTTA: AN ANALYSIS OF HAEMATOLOGICAL AND OTHER DATA FROM 529 PREGNANT WOMEN *by* L. E. Napier *and* Neal Edwards. 135 pp. Thacker, Spink & Co., Calcutta, India. 4-8 Rs.

TECHNIQUES CHIRURGICALES VAGINALES: POSSIBILITÉS ET LIMITES *by* Eric Weber. 144 pp., ill. J. B. Baillière & Fils, Paris. 500 fr.

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OPERATIVE CHIRURGIE *by* Otto Kleinschmidt. 3d ed. 1,545 pp., ill. Springer, Berlin. 96 M.

PHYSICS AND THE SURGEON *by* H. S. Souttar. 60 pp. Blackwell Scientific Publications, Oxford. 7*s.* 6*d.*

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THE 1948 YEAR BOOK OF NEUROLOGY, PSYCHIATRY AND NEUROSURGERY *edited by* Hans H. Reese *et al.* 750 pp., ill. Year Book Publishers, Chicago. $5

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OPHTHALMOLOGY IN THE WAR YEARS, 1944-1946, VOLUME II *edited by* Meyer Wiener. 977 pp. Year Book Publishers, Chicago. $16

DISEASES OF THE FUNDUS OCULI WITH ATLAS *by* Adalbert Fuchs. 337 pp. Blakiston Co., Philadelphia. $30

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ENURESIS OR BED-WETTING *by* R. J. Batty. 2d ed. 103 pp., ill. Staples Press, London. 9*s.* 6*d.*

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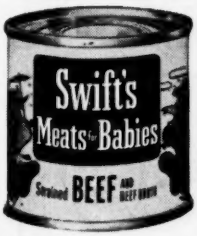

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ISOTOPIC CARBON: TECHNIQUES IN ITS MEASUREMENT AND CHEMICAL MANIPULATION *by* Melvin Calvin *et al.* 376 pp., ill. John Wiley & Sons, New York City. $5.50

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The editors will pay $1 for each story published. No contributions will be returned. Send your experiences to the Patients I Have Met Editor, MODERN MEDICINE, 84 South Tenth St., Minneapolis 3, Minn.

Reassured

My maiden name is used on my M.D. degree, but I now go by my married name. Every once in a while a patient used to notice my medical school diploma hanging on the wall. Having one name on the diploma and another on my office door was always good for a laugh. But the joke wore thin. In an effort to forestall it, I had my marriage license framed and hung alongside the diploma. Shortly afterward I realized that several teenagers who had been patients of mine for some time had come in to ask me questions on marriage. I finally questioned one of them about this sudden interest.

"Oh," she said, "we thought it would be all right now. Before we thought that you were an old maid and didn't know the answers either."—T.E.

When told that she would have to undergo a routine smear test, the patient asked, "Will it spoil my reputation?"—G.M.C.

"Listen, she's telling them about my operation."

Research shows how your patients can have good food at less cost

Full-year field check by 19 Universities* establishes significant data on food costs. Study compares COSTS AND AVAILABILITY of 12 commonly used Fruits and Vegetables in their four marketable forms—Fresh, Frozen, in Glass and in Cans.

In these days of high prices, people ask: "How can I get more food value for my food dollar?" 19 American universities sought the answer in a recent 12-months' research project. Results boil down to this: *Penny for penny, canned foods in general give consumers more food for their money, as well as more nutritional values. Most foods in cans cost less than the same foods in glass — less than fresh foods—and far less than frozen foods.*

SOUND RECOMMENDATION

As you know, no matter how good a particular food may be from the nutritional standpoint, if it is not readily available, or if the price is high—that food is of little practical value. Therefore, the known nutritional values of food in cans, plus the *high* percentage of year-round availability and the *low* cost of canned foods in general, are a winning combination. Results of this pioneering coast-to-coast research again demonstrate how important canned foods are in relation to improved national nutrition. Their variety, their convenience for storage and use, together with their availability and economy, constitute a sound basis, we believe, for your recommending this solution to today's high cost of living.

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*For full details see "Comparative Cost and Availability of Canned, Glassed, Frozen, and Fresh Fruits and Vegetables" in the April issue of the *Journal of the American Dietetic Assn.*

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Caught on Quick

My son fresh from his big city internship had just joined me in my country practice. On our first trip together I told him I would take care of the first house call and let him observe, as this phase of country practice would be new to him. We stopped at the house of a middle-aged neurotic woman whose chief complaint was weakness. I told her to cut down on her smoking and eat balanced meals.

After we left the house I pointed out that I arrived at that particular advice by noticing the filled ashtrays, a half-filled teacup, and an open box of crackers. My son said he thought he got the angle and asked if he might take care of the next patient. She too turned out to be a woman in bed complaining of weakness.

After taking her temperature the youngster said, "Mrs. Brown, I think you've been working too hard at your religion."

I was well pleased, and complimented my son on his astuteness.

"Well, Dad," he said, "when I reached down to get the thermometer out of the bag, I saw the minister under the bed."—D.E.

"Something's haywire. I'm getting the Milton Berle show!"

Common Knowledge

In the days before the present palatable cod-liver oil products were on the market, a three-month-old infant ill with fatty indigestion was brought to my office. The mother said she had been giving the baby a tablespoonful of cod-liver oil after each feeding.

Explaining that she had overdosed the child, I suggested that the oil be entirely omitted until the baby recovered and then be resumed in much smaller amounts.

The mother rose from her chair indignantly and snapped, "Well, I'm not paying for that kind of advice. Even the radio announcer knows that every child needs cod-liver oil every day."—H.C.T.

Detailed Dosage Data for Physicians

A 20-page brochure prepared exclusively for the medical profession presents busy physicians with detailed dosage information relating to quantity, frequency and duration of administration in relation to menses, as well as indications, rationale, etc., regarding ERGOAPIOL (Smith) with SAVIN. This time-tested uterine tonic is thoroughly described in this brochure, "Menstrual Disorders—Their Significance and Symptomatic Treatment". A copy, available to physicians only, will be supplied on request. Ethical since its inception, ERGOAPIOL (Smith) with SAVIN is dispensed only on your prescription.

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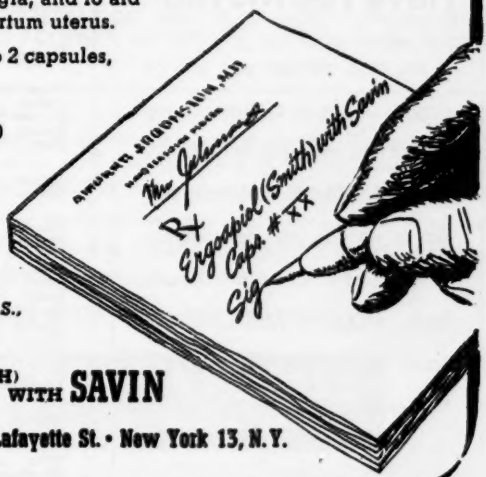

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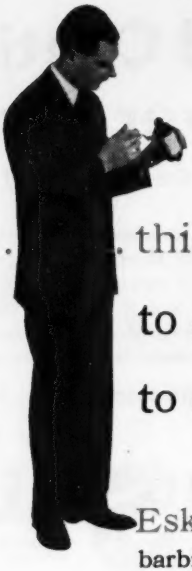

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1. Friedlaender, A. S., and Friedlaender, S.: Annals of Allergy, 6: 23-29, Jan.-Feb., 1948.

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